CNYCC Project 3ai Agreement
"Primary Care Behavioral Health Integration"

This project agreement ("Agreement") is made and entered into this_____day of _____, 2016 ("Effective Date") by and between Central New York Care Collaborative, Inc. ("CNYCC"), a New York not-for-profit corporation, located 109 Otisco St. 2nd Floor Syracuse, NY 13204 and _____, ("Project Participant") located at _____. Each may be referred to as a "Party" or collectively as the "Parties."

Recitals

A. The New York State Department of Health (DOH) has: (i) approved the CNYCC Project Plan submitted to form a Performing Provider System (PPS) under the New York State Delivery System Reform Incentive Payment Program (DSRIP) to serve individuals enrolled in Medicaid and uninsured individuals in the counties of Cayuga, Lewis, Madison, Oneida, Onondaga and Oswego (CNYCC Region) and (ii) designated CNYCC as the PPS Lead.

B. Among other projects, CNYCC has elected to undertake Project 3ai, also known as Primary Care Behavioral Health Integration ("PPS Project"). Project Participant wishes to participate in the PPS Project and has agreed to collaborate with CNYCC and other providers in the CNYCC network (CNYCC Network) in order to implement the PPS Project.

C. The objective of PPS Project is integration of mental health and substance abuse with primary care services to ensure coordination of care for both services.

AGREEMENT

In consideration of the forgoing, the mutual covenants contained herein and for purposes of furthering immediate implementation of the PPS Project, the Parties agree as follows:

ARTICLE I
DEFINITIONS

The terms used in this Agreement shall have the following meanings.

1. **"CMS"** means the Centers for Medicare and Medicaid Services.

2. **"Compliance Program"** means the program established by CNYCC to prevent, detect, and address compliance issues that arise with respect to PPS operations, projects or activities.

3. **"DSRIP Requirements"** means the requirements of DSRIP as set forth in DOH or CMS regulations, guidelines, and guidance statements, as amended from time to time

4. **"HIPAA"** means the Health Insurance Portability and Accountability Act of 1966, Public Law 104-191, as amended by the Health Insurance Technology for Economic Clinical Health Act (HITECH) and any regulations, rules, and guidance issued pursuant to HIPAA and the HITECH Act (collectively "HIPAA").

5. **"Partner Organization Agreement"** means the agreement between CNYCC and participating Partner Organizations that sets forth the rights and obligations of the parties in relation to implementation of the CYNCC Project Plan.

6. **"Partner Organizations"** means the organizations that execute an agreement to participate in the PPS as a Partner Organization.

7. **"PPS"** has the meaning set forth in Recital A and includes the network of health care providers, community-based organizations, vendors, and state, county and municipal agencies that participate in PPS projects, operations, or activities to implement the CNYCC Project Plan and meet DSRIP goals.

8. **"PPS Policies and Procedures"** means policies and procedures duly adopted by CNYCC's Board of Directors or governance committees of the Board of Directors, in accordance with CNYCC's bylaws.

9. **"PHI"** means Protected Health Information as defined under HIPAA.

10. **"Project Protocols"** means protocols adopted by CNYCC to implement the PPS Project, as may be amended from time to time, and as developed by CNYCC in collaboration with Partner Organizations throughout the duration of the PPS Project.

ARTICLE II
PROJECT IMPLEMENTATION AND REQUIREMENTS

Section 2.1. CNYCC Obligations. CNYCC shall plan and manage the PPS Project, including but not limited to developing or identifying Project Protocols and evidence-based practice guidelines required for project implementation, tracking project performance, and reporting as required by DSRIP to DOH.

Section 2.2. Project Participant Obligations and Services. Project Participant shall:

(a) Comply with PPS Project requirements, including but not limited to requirements set forth in: (i) this Agreement; and (ii) Project Protocols, as may be adopted and amended from time to time by CNYCC, except that Project Protocols shall not override the professional judgment of Partner Organization and its licensed health care professionals in treating patients in individual cases;

(b) Provide services to Medicaid beneficiaries and uninsured individuals or conduct activities to prepare for or undertake Project implementation ("Project Deliverables") as set forth in Appendices to this Agreement. Such services or Activities shall be provided in accordance with generally accepted standards of practice for clinical services, if any, and in accordance with applicable federal, state, and local laws and regulation.

(c) Participate in secure messaging and information exchange with CNYCC and other providers in the CNYCC network and exchange data, as required to implement the PPS Project;

(d) Maintain information and data as required by CNYCC, including but not limited to the information and data elements listed in Appendix C, attached to this Agreement; and

(f) Report information to CNYCC as required by the data reporting protocol set forth in Appendix C. Project Participant understands that CNYCC will rely on the information submitted by Project Participant in submitting reports to DOH and agrees that all data, reports and documentation submitted by Project Participant under this Agreement shall be accurate and complete.

ARTICLE III
PAYMENT TERMS

Section 3.1. CNYCC shall pay Project Participant for Project Deliverables and performance in accordance with the terms and conditions set forth in Appendix B to this Agreement. The payment terms set forth in Appendix B shall be subject to the contingencies for payment set forth in Section 4.3 of the Partner Organization Agreement.

ARTICLE IV
PARTNER ORGANIZATION AGREEMENT

Section 4.1. Partner Organization Agreement. The Parties have entered into a Partner Organization Agreement setting forth their respective rights and obligations in implementing the CNYCC Project Plan. This Agreement shall be interpreted and relied upon by the Parties as an addendum to the Partner Organization Agreement.

ARTICLE V
TERM AND TERMINATION

Section 5.1. Term. This Agreement shall terminate on March 31, 2020, unless the Agreement is terminated earlier in accordance with the provisions of this Article. The Parties may agree in writing to renew the Agreement for a specified time period.

Section 5.2. Termination by CNYCC. CNYCC may terminate this Agreement in the event that Project Participant breaches a material term of this Agreement and fails to cure such breach within thirty (30) days after receiving written notice from CNYCC specifying the nature of the breach (or such other longer cure period as CNYCC deems reasonable under the circumstances). In addition, CNYCC may terminate this Agreement upon twenty-four (24) hours' written notice to Project Participant if any license, certification or government approval of Project Participant material to its performance under this Agreement is suspended, terminated, revoked, or surrendered.

Section 5.3. Termination by Project Participant. Project Participant may terminate this Agreement in the event that CNYCC breaches a material term of this Agreement and fails to cure such breach within thirty (30) days after receiving written notice from Project Participant specifying the nature of the breach (or such other longer cure period as Project Participant deems reasonable under the circumstances). In addition, Project Participant may terminate this Agreement upon twenty-four (24) hours' written notice to CNYCC, if CNYCC is suspended or excluded from DSRIP or the New York State Medicaid Program.

ARTICLE VI
DATA USE AND CONFIDENTIALITY

Section 6.1. Business Associate Agreement. The Parties agree that in order to implement the PPS Project, they may need to exchange PHI. The Parties have entered into a Business Associate Agreement that covers the exchange of PHI that may occur pursuant to this Agreement, or shall enter into a Business Associate Agreement, as a condition of entering into this Agreement.

Section 6.2. Duty to Protect Confidential Medical Information. The Parties agree that they will only use and share PHI with one another and, as necessary, with other providers in the CNYCC Network in a manner consistent with: (i) HIPAA; (ii) all other applicable state and federal laws and regulations; (iii) DSRIP program guidance issued by DOH or CMS; (iv) the Business Associate Agreement entered into by the Parties; and (v) applicable PPS Policies and Procedures for the exchange of PHI and Medicaid Confidential Data. To the extent legally required, or required by PPS Policies and Procedures, Project Participant shall seek any necessary consent from Patients with respect to any data to be shared for DSRIP purposes.

Section 6.3. Other Confidential Information. The exchange of all other information defined as confidential in accordance with the Partner Organization Agreement shall be governed by Article XII of that agreement.

ARTICLE VII
RECORD RETENTION

Section 7.1. Obligation to Maintain Records. The Parties shall maintain and retain operational, financial, administrative, and medical records, and other documents related to the subject matter of this Agreement in accordance with applicable law, DSRIP Requirements, and Article XIII OF THE Partner Organization Agreement.

ARTICLE VIII
DISPUTE RESOLUTION

Section 8.1. Either Party may initiate the Dispute Resolution Process in relation to a disagreement between the Parties that arises from or is related to performance under this Agreement, provided that if a Party is served with notice of a breach under this Agreement by the other Party, the Party notified must initiate the Dispute Resolution Process with three (3) business days of receiving the notice of breach and shall participate in good faith in the Dispute Resolution Process to expedite a resolution to the dispute. Neither Party shall use the Dispute Resolution Process to delay or avoid performance or termination of this Agreement.

ARTICLE IX
REPRESENTATIONS AND WARRANTIES

Section 9.1. Section Representations and Warranties of CNYCC. CNYCC hereby represents and warrants to Project Participant that neither CNYCC, nor any of its employees, agents, or contractors who will perform services pursuant to this Agreement, are excluded from participation in Medicare or Medicaid or any other federal or state health insurance program.

Section 9.2. Representations and Warranties of Project Participant. Project Participant hereby represents and warrants to CNYCC that:

(a) Neither Project Participant nor any of its subsidiaries, parent entities, employees, agents, or contractors are excluded from participation in the Medicare or Medicaid programs or any other federal or state health insurance program; and

(b) Project Participant's ability to provide health care services in New York State or any other jurisdiction is not now revoked, limited, suspended, or otherwise restricted in any manner.

ARTICLE X
INDEPENDENT CONTRACTORS

CNYCC and Project Participant understand and agree that the Parties intend to act and perform their respective obligations under this Agreement and DSRIP as independent contractors and that neither CNYCC nor Project Participant is an employee, partner, or joint venture of the other.

ARTICLE XI
LEGAL COMPLIANCE

Section 11.1. Compliance with Laws and Policies. In carrying out the terms of this Agreement, both Parties shall comply with all applicable federal, state and local laws, regulations and rules, DSRIP Requirements, and the CNYCC Compliance Program.

ARTICLE XII
INDEMNIFICATION AND LIMITATION OF LIABILITY

Section 12.1. Indemnification. Each Party agrees to indemnify the other Party and its officers, directors, employees, agents, and subsidiaries for any and all claims, losses, liabilities, costs and expenses, including reasonable attorneys' fees and costs, arising from third party claims or government enforcement action asserted or incurred in connection with the indemnifying Party's: (a) failure to perform its obligations under this Agreement; (b) willful misconduct or negligent acts or omissions in carrying out services and obligations under this Agreement; or (c) the Party's violation of any law, statute, regulation, rule or standard of care. This indemnification obligation shall survive the termination of this Agreement. Neither Party shall indemnify the other Party for the negligent acts or omissions of any other Partner Organization or any other third party.

ARTICLE XIII
NOTICE

Section 13.1. Delivery of Notice. Except as otherwise specified herein, all notices under this Agreement shall be in writing and shall be delivered personally, mailed by first-class, registered, certified mail or overnight mail, return receipt requested, or via email:

If to CNYCC:	**If to Project Participant:**
Attn: Virginia Opipare	Attn:_____
Title: Executive Director	Title:_____
Address: 109 Otisco St. 2nd Floor Syracuse, NY 13204	Address:_____ _____
Email: Virginia.Opipare@cnycares.org	Email:_____

Section 13.2. Change of Notice Recipient. Each Party may designate in writing a new address to which any notice shall be delivered.

ARTICLE XIV
GENERAL PROVISIONS

Section 14.1. Amendment. This Agreement may only be amended, altered, or modified by a written agreement executed by the Parties, except: (i) for the reporting requirements set forth in Appendix B; and (ii) if changes to DSRIP Requirements mandated by CMS or DOH require amendment of this Agreement, CNYCC may amend this Agreement to the extent necessary to comply with such DSRIP Requirements and shall promptly notify Project Participant in writing of such amendments.

Section 14.2. Assignment. This Agreement may not be assigned by either Party without the prior written consent of the other Party.

Section 14.3. Entire Agreement. This Agreement supersedes all prior oral or written agreements, commitments, or understandings between the Parties with respect to the matters provided for herein, except for the Business Associate Agreement entered into between the Parties, and the Partner Organization Agreement, if the Parties have entered into such agreements at the time this Agreement is executed by the Parties.

Section 14.4. Waivers; Amendments. The rights and remedies of the Parties hereunder are cumulative and are not exclusive of any rights or remedies that they would otherwise have. This Agreement may be waived, amended or modified only pursuant to an agreement or agreements in writing entered into by the Parties.

Section 14.5. Governing Law. This Agreement shall be construed and enforced in accordance with the laws of the State of New York without regard to its conflicts of law rules.

Section 14.6. Non-Discrimination. Access to services under this Agreement will be based solely on criteria of prognosis and need for care and not on the basis of race, age, sex, color, religion, national origin, marital status, sexual orientation, disability, sponsorship, source of payment or other similar criteria.

Section 14.7. Non-Exclusivity. Nothing in this Agreement shall prohibit either Party from affiliating or contracting with any other entity for any purpose whatsoever.

Section 14.8. Severability. Any provision of this Agreement held to be invalid, illegal or unenforceable in any jurisdiction shall, as to such jurisdiction, be ineffective to the extent of such invalidity, illegality or unenforceability without affecting the validity, legality and enforceability of the remaining provisions hereof; and the invalidity of a particular provision in a particular jurisdiction shall not invalidate such provision in any other jurisdiction.

Section 14.9. Counterparts; Integration; Effectiveness. This Agreement may be executed in counterparts, each of which shall constitute an original, but all of which when taken together shall constitute a single contract. Delivery of an executed counterpart of a signature page of this Agreement by facsimile or other electronic imaging shall be effective as delivery of a manually executed counterpart of this Agreement.

IN WITNESS WHEREOF, the Parties have caused this Agreement to be duly executed as of the Effective Date.

PROJECT PARTICIPANT

By: _____
Name: _____
Title: _____

CENTRAL NEW YORK CARE COLLABORATIVE, INC.

By: _____
Name: Virginia Opipare
Title: Executive Director

Appendix A

Project Requirements

The New York State Department of Health (DOH) has designated the requirements and timeline for completion for milestones for DSRIP Project 3ai (Project Requirements) that includes PPS participants from across the continuum of care. The following pages list the Project Requirements as set forth most recently by DOH.

Partner Organization shall make a good faith commitment to participating in meeting the Project Requirements as listed on the following pages by the deadlines specified below, to the extent such requirements are applicable to Partner Organization given the Project 3ai model it selects (Model 1, Model 2, or Model 3), nature of the services it provides, and its role in PPS projects. Such a good faith commitment is a prerequisite for receipt of project payments identified in Appendix B and will be required for receipt of project payments in future DSRIP years by partner organizations of types not specified for payment in DSRIP Year 1.

(A) Requirements with the "Unit Level" designation of the Project Participant's provider type are the individual responsibility of the Project Participant, including the provision to CNYCC of the related "Data Source(s)" required to substantiate completion of the project requirement.

(B) Requirements with the "Unit Level" designation of "Project" are the joint responsibility of CNYCC and its participating partner organizations. The Project Participant may bear some individual responsibility for activities related to the requirement including the provision of the related "Data Source(s)" required to substantiate completion of the project requirement.

Requirement Color:	Project 2ai Requirement Completed By:
Green	End of DY2Q4 (March 31, 2017)
Yellow	End of DY3Q4 (March 31, 2018)
Orange	End of DY4Q4 (March 21, 2019)

Project Domain	**Clinical Improvement Projects (Domain 3)**
Project ID	**3.a.i (Model 1)**
Project Title	**Integration of primary care and behavioral health services**

Index Score = 39

Definition of Actively Engaged	The total ~~of~~ number of patients engaged ~~per~~ in each of the three models in this project, including: A. PCMH/APC Service Site: Number of patients receiving appropriate preventive care screenings that include mental health/SA. ~~Number of patients screened (PHQ-9 / SBIRT)~~ B. Behavioral Health Site: Number of patients receiving primary care services at a participating mental health or substance abuse site. C. IMPACT: Number of patients screened (PHQ-2 or 9 / SBIRT).

Project Requirement		**Metric/Deliverable**	**Data Source(s)**	**Old Data Source(s)**	**Unit Level**
1	Co-locate behavioral health services at primary care practice sites. All participating primary care practices must meet 2014 NCQA level 3 PCMH or Advance Primary Care Model standards by DY 3.	All practices meet NCQA 2014 Level 3 PCMH and/or APCM standards by the end of DY3.	**List of participating NCQA-certified and/or APC-approved physicians/practioners (APC Model requirements as determined by NY SHIP)**; Certification documentation	**List of participating NCQA-certified practices**; Certification documentation	Provider (PCP)
		Behavioral health services are co-located within PCMH/APC practices and are available.	List of practitioners and licensure performing services at PCMH **and/or APCM** sites; Behavioral health practice schedules	List of practitioners and licensure performing services at PCMH sites; Behavioral health practice schedules	Provider (BH)
2	Develop collaborative evidence-based standards of care including medication management and care engagement process.	Regularly scheduled formal meetings are held to develop collaborative care practices.	Meeting schedule; Meeting agenda; Meeting minutes; List of attendees	Meeting schedule; Meeting agenda; Meeting minutes; List of attendees	Project
		Coordinated evidence-based care protocols are in place, including medication management and care engagement processes.	Evidence-based practice guidelines; Implementation plan; **Policies and procedures regarding frequency of updates to guidelines and protocols**	Evidence-based practice guidelines; Implementation plan; Policies and procedures for frequency of updates to documentation; **Version log**	Project

Changed from: Behavioral health services are co-located within PCMH practices are available during all practice hours.

Project Domain	**Clinical Improvement Projects (Domain 3)**
Project ID	**3.a.i (Model 1)**
Project Title	**Integration of primary care and behavioral health services**

Index Score = 39

Definition of Actively Engaged	The total ~~of~~ number of patients engaged ~~per~~ in each of the three models in this project, including: A. PCMH/APC Service Site: Number of patients receiving appropriate preventive care screenings that include mental health/SA. ~~Number of patients screened (PHQ-9 / SBIRT)~~ B. Behavioral Health Site: Number of patients receiving primary care services at a participating mental health or substance abuse site. C. IMPACT: Number of patients screened (PHQ-2 or 9 / SBIRT).

Project Requirement		Metric/Deliverable	Data Source(s)	Old Data Source(s)	Unit Level
3	Conduct preventive care screenings, including behavioral health screenings (PHQ-2 or 9 for those screening positive, SBIRT) implemented for all patients to identify unmet needs.	Policies and procedures are in place to facilitate and document completion of screenings.	Screening policies and procedures	Screening policies and procedures	Project
		Screenings are documented in Electronic Health Record.	**Screenshots or other evidence of notifications of patient identification and screening alerts**; EHR Vendor documentation	**Screenshot of EHR**; EHR Vendor documentation	Project
		At least 90% of patients receive screenings at the established project sites (Screenings are defined as industry standard questionnaires such as PHQ-2 or 9 for those screening positive, SBIRT).	Roster of identified patients; Number of screenings completed	Roster of identified patients; Number of screenings completed	Project
		Positive screenings result in "warm transfer" to behavioral health provider as measured by documentation in Electronic Health Record.	Sample EHR demonstrating that warm transfers have occurred	Sample EHR demonstrating that warm transfers have occurred	Provider (PCP)
4	Use EHRs or other technical platforms to track all patients engaged in this project.	EHR demonstrates integration of medical and behavioral health record within individual patient records.	Sample EHR demonstrating both medical and behavioral health Project Requirements	Sample EHR demonstrating both medical and behavioral health Project Requirements	Project
		PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.	Sample data collection and tracking system; EHR completeness reports (necessary data fields are populated in order to track project implementation and progress)	Sample data collection and tracking system; EHR completeness reports (necessary data fields are populated in order to track project implementation and progress)	Project

Changed from: Conduct preventive care screenings, including behavioral health screenings (PHQ-9, SBIRT) implemented for all patients to identify unmet needs.

Changed from: 100% of Individuals receive screenings at the established project sites (Screenings are defined as industry standard questionnaires such as PHQ-9, SBIRT).

Project Domain	**Clinical Improvement Projects (Domain 3)**
Project ID	**3.a.i (Model 2)**
Project Title	**Integration of primary care and behavioral**

Index Score = 39

Definition of Actively Engaged	The total ~~of~~ number of patients engaged ~~per~~ in each of the three models in this project, including: A. PCMH/APC Service Site: Number of patients receiving appropriate preventive care screenings that include mental health/SA. ~~Number of patients screened (PHQ-9 / SBIRT)~~ B. Behavioral Health Site: Number of patients receiving primary care services at a participating mental health or substance abuse site. C. IMPACT: Number of patients screened (PHQ-2 or 9 / SBIRT).

Project Requirement		Metric/Deliverable	Data Source(s)	Old Data Source(s)	Unit Level
1	Co-locate primary care services at behavioral health sites.	PPS has achieved NCQA 2014 Level 3 PCMH or Advanced Primary Care Model Practices by the end of DY3.	**List of participating NCQA-certified and/or APC-approved physicians/practioners (APC Model requirements as determined by NY SHIP);** Certification documentation	**List of participating NCQA-certified practices**; Certification documentation	Provider (PCP)
		Primary care services are co-located within behavioral Health practices and are available.	List of practitioners and licensure performing services at behavioral health site; behavioral health practice schedules.	~~List of practitioners and licensure~~ performing services at behavioral health site; behavioral health practice schedules.	Provider (PCP, BH)
2	Develop collaborative evidence-based standards of care including medication management and care engagement process.	Regularly scheduled formal meetings are held to develop collaborative care practices.	Meeting schedule; Meeting agenda; Meeting minutes; List of attendees	Meeting schedule; Meeting agenda; Meeting minutes; List of attendees	Project
		Coordinated evidence-based care protocols are in place, including a medication management and care engagement process.	Documentation of evidence-based practice guidelines; Implementation plan; Policies and procedures regarding frequency of updates to evidence-based practice documentation	Documentation of evidence-based practice guidelines; Implementation plan; Policies and procedures regarding frequency of updates to evidence-based practice documentation; **version log**	Project

Changed from: Primary care services are co-located within behavioral Health practices are available during all practice hours.

Project Domain	**Clinical Improvement Projects (Domain 3)**
Project ID	**3.a.i (Model 2)**
Project Title	**Integration of primary care and behavioral**

Index Score = 39

Definition of Actively Engaged	The total ~~of~~ number of patients engaged ~~per~~ in each of the three models in this project, including: A. PCMH/APC Service Site: Number of patients receiving appropriate preventive care screenings that include mental health/SA. ~~Number of patients screened (PHQ-9 / SBIRT)~~ B. Behavioral Health Site: Number of patients receiving primary care services at a participating mental health or substance abuse site. C. IMPACT: Number of patients screened (PHQ-2 or 9 / SBIRT).

Project Requirement		Metric/Deliverable	Data Source(s)	Old Data Source(s)	Unit Level
3	Conduct preventive care screenings, including behavioral health screenings (PHQ-2 or 9 for those screening positive, SBIRT) implemented for all patients to identify unmet needs.	Screenings are conducted for all patients. Process workflows and operational protocols are in place to implement and document screenings.	Screening **protocols** included in policies and procedures; **Log demonstrating the number of screenings completed**	Screening **procedures** ~~included in PCMH~~ policies and procedures; **Log demonstrating number of screenings completed**	Project
		Screenings are documented in Electronic Health Record.	**Screenshots or other evidence of notifications of patient identification and screening alerts**; EHR Vendor documentation	**Screenshot of EHR**; EHR Vendor documentation	Project
		At least 90% of patients receive screenings at the established project sites (Screenings are defined as industry standard questionnaires such as PHQ-2 or 9 for those screening positive, SBIRT).	Screenings documented in EHR	Screenings documented in EHR	Project
		Positive screenings result in "warm transfer" to behavioral health provider as measured by documentation in Electronic Health Record.	Sample EHR demonstrating that warm transfers have occurred	Sample EHR demonstrating that warm transfers have occurred	Provider (PCP)
4	Use EHRs or other technical platforms to track all patients engaged in this project.	EHR demonstrates integration of medical and behavioral health record within individual patient records.	Sample EHR demonstrating both medical and behavioral health Project Requirements	Sample EHR demonstrating both medical and behavioral health Project Requirements	Project
		PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.	Sample data collection and tracking system; EHR completeness reports (necessary data fields are populated in order to track project implementation and progress)	Sample data collection and tracking system; EHR completeness reports (necessary data fields are populated in order to track project implementation and progress)	

Changed from: Conduct preventive care screenings, including behavioral health screenings (PHQ-9, SBIRT) implemented for all patients

Changed from: 100% of Individuals receive screenings at the established project sites (Screenings are defined as industry standard questionnaires such as PHQ-9, SBIRT).

Project Domain	**Clinical Improvement Projects (Domain 3)**
Project ID	**3.a.i (Model 3)**
Project Title	**Integration of primary care and behavioral health services**

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	Project Requirement	Metric/Deliverable	Data Source(s)	Old Data Source(s)	Unit Level
1	Implement IMPACT Model at Primary Care Sites.	PPS has implemented IMPACT Model at Primary Care Sites.	**Quarterly report narrative demonstrating successful implementation of project requirements**	**Quarterly reports demonstrating successful implementation of project requirements**	Provider (PCP Practices)
2	Utilize IMPACT Model collaborative care standards, including developing coordinated evidence-based care standards and policies and procedures for care engagement.	Coordinated evidence-based care protocols are in place, including a medication management and care engagement process to facilitate collaboration between primary care physician and care manager.	Documentation of evidence-based practice guidelines; Implementation plan; Policies and procedures regarding frequency of updates to evidence-based practice documentation	Documentation of evidence-based practice guidelines; Implementation plan; Policies and procedures regarding frequency of updates to evidence-based practice documentation; **version log**	Project
		Policies and procedures include process for consulting with Psychiatrist.	Documentation of evidence-based practice guidelines	Documentation of evidence-based practice guidelines	Project
3	Employ a trained Depression Care Manager meeting requirements of the IMPACT model.	PPS identifies qualified Depression Care Manager (can be a nurse, social worker, or psychologist) as identified in Electronic Health Records.	**Identification of Depression Care Manager via Electronic Health Records**	**Identification of Depression Care Manager; via Electronic Health Records**	Project
		Depression care manager meets requirements of IMPACT model, including coaching patients in behavioral activation, offering course in counseling, monitoring depression symptoms for treatment response, and completing a relapse prevention plan.	**Evidence of IMPACT model training and implementation**; Sample EHR demonstrating relapse prevention plans, patient coaching, and other IMPACT interventions	**Evidence of IMPACT model training and implementation experience**; Sample EHR demonstrating relapse prevention plans, patient coaching, and other IMPACT interventions	Project

Project Domain	**Clinical Improvement Projects (Domain 3)**
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	Project Requirement	Metric/Deliverable	Data Source(s)	Old Data Source(s)	Unit Level
4	Designate a Psychiatrist meeting requirements of the IMPACT Model.	All IMPACT participants in PPS have a designated Psychiatrist.	Register of IMPACT participants and designated psychiatrist; Policies and procedures in place to follow up with care of patients; Electronic Health Record identifying Psychiatrist for eligible patients	Register of IMPACT participants and designated psychiatrist; Policies and procedures in place to follow up with care of patients; Electronic Health Record identifying Psychiatrist for eligible patients	Project
5	Measure outcomes as required in the IMPACT Model.	At least 90% of patients receive screenings at the established project sites (Screenings are defined as industry standard questionnaires such as PHQ-2 or 9 for those screening positive, SBIRT).	Roster of screened patients	Roster of screened patients	Project
6	Provide "stepped care" as required by the IMPACT Model.	In alignment with the IMPACT model, treatment is adjusted based on evidence-based algorithm that includes evaluation of patient after 10-12 weeks after start of treatment plan.	Documentation of evidence-based practice guidelines for stepped care; Implementation plan	Documentation of evidence-based practice guidelines for stepped care; Implementation plan	Project
7	Use EHRs or other technical platforms to track all patients engaged in this project.	EHR demonstrates integration of medical and behavioral health record within individual patient records.	Sample EHR demonstrating both medical and behavioral health Project Requirements	Sample EHR demonstrating both medical and behavioral health Project Requirements	Project
		PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.	Sample data collection and tracking system; EHR completeness reports (necessary data fields are populated in order to track project implementation and progress)	Sample data collection and tracking system; EHR completeness reports (necessary data fields are populated in order to track project implementation and progress)	Project

Changed from: 100% of Individuals receive screenings at the established project sites (Screenings are defined as industry standard questionnaires such as PHQ-9, SBIRT).

Appendix B
DSRIP Year 1 Payment for Project 3ai Activities: Eligibility & Stipulations

Payment Mechanism 1: Per Member per Month (PMPM) for engaging patients in ongoing integrated care or engaging patients in evidence-based screenings (medical, mental health, or substance abuse).

- Eligible Partner Organizations: Behavioral health organizations and organizations that provide primary care that intend to provide integrated primary care/behavioral health services under Project 3ai Model 1, Model 2, and/or Model 3

  ❒ My organization is an eligible, *safety net* partner organization and intends to undertake necessary project activities in pursuit of this project payment type under:

  - ❒ Model 1: Integration of Behavioral Health Services in the Primary Care Setting
  - ❒ Model 2: Integration of Primary Care Services in the Behavioral Health Setting
  - ❒ Model 3: IMPACT Model (Depression Care Management in the Primary Care Setting)

  ❒ My organization is an eligible, *safety net* partner organization and intends to fulfill necessary project activities in pursuit of this project payment type through a subcontract with organization: _____, under:

  - ❒ Model 1: Integration of Behavioral Health Services in the Primary Care Setting
  - ❒ Model 2: Integration of Primary Care Services in the Behavioral Health Setting
  - ❒ Model 3: IMPACT Model (Depression Care Management in the Primary Care Setting)

  ❒ My organization, although an eligible, *safety net* partner organization, **does NOT** intend to undertake necessary project activities in pursuit of this project payment type

  ❒ My organization is an eligible, *non-safety net* partner organization and intends to independently undertake necessary project activities in pursuit of this project payment type, understanding that the amount of funding available to non-safety net participants in aggregate is limited to 5% of the total project valuation under:

  - ❒ Model 1: Integration of Behavioral Health Services in the Primary Care Setting
  - ❒ Model 2: Integration of Primary Care Services in the Behavioral Health Setting
  - ❒ Model 3: IMPACT Model (Depression Care Management in the Primary Care Setting)

❒ My organization is an eligible, *non-safety net* partner organization and intends to undertake necessary project activities in pursuit of this project payment type as a subcontractor of organization: _____, an eligible, *safety net* partner organization

❒ My organization, although an eligible, *non-safety net* partner organization, **does NOT** intend to undertake necessary project activities in pursuit of this project payment type

❒ My organization is not an eligible partner organization of any type above

- Total Amount Available for DY1 Payments: $1,159,593
- Payment Amount Calculation: PMPM ($5.43 gross, $4.62 net) x number of validated, successfully actively engaged patients
- Additional Payment Stipulations:
  - Organizations will submit patient rosters in accordance with project reporting protocols.

Payment Mechanism 2: Lump sum payments for submitting an organization-specific project implementation plan.

- Eligible Partner Organizations: Behavioral health organizations and organizations that provide primary care that intend to provide integrated primary care/behavioral health services under Project 3ai Model 1, Model 2, and/or Model 3

  ❒ My organization is an eligible, *safety net* partner organization and intends to undertake necessary project activities in pursuit of this project payment type under:

  ❒ Model 1: Integration of Behavioral Health Services in the Primary Care Setting
  - Number of participating, distinct primary care sites within contracting partner organization: _____.
    Please list: _____.

  ❒ Model 2: Integration of Primary Care Services in the Behavioral Health Setting
  - Number of participating, distinct behavioral health sites within contracting partner organization: _____.
    Please list: _____.

  ❒ Model 3: IMPACT Model (Depression Care Management in the Primary Care Setting)
  - Number of participating, distinct primary care sites within contracting partner organization: _____.
    Please list: _____.

Project Requirement Criteria – Exhibit C

Project: Behavioral Health/Primary Care Integration (3.a.i)

Model 1

NYS Defined Information (cannot be changed or altered)

Project Title	Integration of primary care and behavioral health services
Actively Engaged Definition	The total number of patients receiving appropriate preventive care screenings that include mental/substance abuse.
Counting Criteria	A count of patients who meet the criteria over a 1-year measurement period. Duplicate counts of patients are not allowed. The count is not additive across DSRIP years.
Data Source	EHRs or other IT Platforms (i.e. patient registries).

Clarifying Information:

- The PPS is expected to utilize the preventative care screening based on nationally-accepted best practices determined to be age-appropriate.
- Any staffer working at a PCMH/APCM Service Site who is qualified to perform a preventive care screening can do so. However, preventive care screenings conducted with a patient via telepsychiatry alone will not count within this active engagement definition.
- Appropriate screenings would only count if the PCP or the clinical staff is provided the results of the screen and they are incorporated into the medical record.
- The expectation of co-located primary care-behavioral health site is that there is a licensed behavioral health provider on site engaged in the practice.

CNYCC Defined Details:

In order to be considered actively engaged by definitions set by CNYCC, Medicaid members must:

- Have traditional Medicaid, be dually eligible for Medicaid and Medicare, or be a member of Medicaid Managed Care (e.g. Fidelis, Total Care or United Healthcare) **AND**
- Have received the appropriate preventive care screenings that include mental/substance abuse from the table below **AND**

Screened For:	**Screen Used:**

Depression/Suicide	PHQ-2/PHQ-9/A (depression, adults/adolescents) Edinburgh scale (postpartum depression) CES-DC (Depression Scale for Children) (ages 6-17 yr) Columbia Rating Scale (suicide, children up to adults) Zung-Self Rated Depression Scale Modified Mini Screen (Depression and Anxiety) Mood and Feelings Questionnaire (ages 8-18)
Anxiety	GAD-7 (anxiety, children, adults) SCARED (children, parents) Modified Mini Screen (Depression and Anxiety) PSWQ (youth)
Bipolar disorder	Young Mania Rating Scale (youth) Child Mania Rating Scale-Parent (parent of youth)
Substance Use/Abuse Including Tobacco	CRAFFT (substance abuse, 12-18 yrs) MSSI (substance abuse, adults) CAGE SSI-AOD Simple Screening Instrument for Alcohol and Other Drugs Audit C – for Alcohol ASSIST DAST-10
Social/Emotional/Psychosocial	ASQ-SE (social-emotional, ages at stages, 6 mos to 5 yrs) SDQ-2 (strengths and difficulties, 6-16 yrs) Pediatric Symptom Checklist (Children) Strengths and Difficulties Questionnaires (Children) Modified Overt Aggression Scale (MOAS; clinician rating) MOAS (retrospective; parent) Nisonger Child Behavior Rating Form (CBRF long; parent) Outburst Monitoring Scale NEW
ADHD	Edelbrock Rating Scale Vanderbilt Parent Rating ADHD Rating Scale (adults)
Autism	Modified CHAT (M-CHAT; parent) M-CHAT Follow Up
Eating Disorders	Eating Attitude Test BULIT-R

- Have **NOT** been submitted to other PPSs for payment.

Model 2

NYS Defined Information (cannot be changed or altered)

Project Title	Integration of primary care and behavioral health services
Actively Engaged Definition	The total number of patients receiving primary care services at a participating mental health or substance abuse site.
Counting Criteria	A count of patients who meet the criteria over a 1-year measurement period. Duplicate counts of patients are not allowed. The count is not additive across DSRIP years.
Data Source	EHRs or other IT Platforms (i.e. patient registries).

Clarifying Information:

- Primary Care Services are defined as preventive care screenings billed through Current Procedural Terminology (CPT) codes.
- The mental health are substance abuse sites have to be Partners in the Network Tool in order to count.
- Any staffer working at a Behavioral Health Site who is qualified to perform a preventive care screening as required within the project can do so.
- Appropriate screenings would only count if the PCP or the clinical staff is provided the results of the screen and they are incorporated into the medical record.
- The only types of "primary care providers" that may be utilized to provide primary care services within the BH site are participating PCPs, NPs and physician assistants working closely with a PCP.

CNYCC Defined Details:

In order to be considered actively engaged by definitions set by CNYCC, Medicaid members must:

- Have traditional Medicaid, be dually eligible for Medicaid and Medicare, or be a member of Medicaid Managed Care (e.g. Fidelis, Total Care or United Healthcare) **AND**
- Have received primary care services from the list below at a participating mental health or substance abuse sites **AND**

Topic	**Description**
Abdominal aortic aneurysm screening: men	The USPSTF recommends one-time screening for abdominal aortic aneurysm by ultrasonography in men ages 65 to 75 years who have ever smoked.
Alcohol misuse: screening and counseling	The USPSTF recommends that clinicians screen adults age 18 years or older for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse.
Bacteriuria screening: pregnant women	The USPSTF recommends screening for asymptomatic bacteriuria with urine culture in pregnant women at 12 to 16 weeks' gestation or at the first prenatal visit, if later.

Blood pressure screening in adults	The USPSTF recommends screening for high blood pressure in adults aged 18 years or older. The USPSTF recommends obtaining measurements outside of the clinical setting for diagnostic confirmation before starting treatment.
BRCA risk assessment and genetic counseling/testing	The USPSTF recommends that primary care providers screen women who have family members with breast, ovarian, tubal, or peritoneal cancer with one of several screening tools designed to identify a family history that may be associated with an increased risk for potentially harmful mutations in breast cancer susceptibility genes (*BRCA1* or *BRCA2*). Women with positive screening results should receive genetic counseling and, if indicated after counseling, BRCA testing.
Breast cancer screening	The USPSTF recommends screening mammography for women, with or without clinical breast examination, every 1 to 2 years for women age 40 years and older.
Cervical cancer screening	The USPSTF recommends screening for cervical cancer in women ages 21 to 65 years with cytology (Pap smear) every 3 years or, for women ages 30 to 65 years who want to lengthen the screening interval, screening with a combination of cytology and human papillomavirus (HPV) testing every 5 years.
Chlamydia screening: women	The USPSTF recommends screening for chlamydia in sexually active women age 24 years or younger and in older women who are at increased risk for infection.
Cholesterol abnormalities screening: men 35 and older	The USPSTF strongly recommends screening men age 35 years and older for lipid disorders.
Cholesterol abnormalities screening: men younger than 35	The USPSTF recommends screening men ages 20 to 35 years for lipid disorders if they are at increased risk for coronary heart disease.
Cholesterol abnormalities screening: women 45 and older	The USPSTF strongly recommends screening women age 45 years and older for lipid disorders if they are at increased risk for coronary heart disease.
Cholesterol abnormalities screening: women younger than 45	The USPSTF recommends screening women ages 20 to 45 years for lipid disorders if they are at increased risk for coronary heart disease.
Colorectal cancer screening	The USPSTF recommends screening for colorectal cancer using fecal occult blood testing, sigmoidoscopy, or colonoscopy in adults beginning at age 50 years and continuing until age 75 years. The risks and benefits of these screening methods vary.
Depression screening: adolescents	The USPSTF recommends screening adolescents (ages 12-18 years) for major depressive disorder when systems are in place to ensure accurate diagnosis, psychotherapy (cognitive-behavioral or interpersonal), and follow-up.

Depression screening: adults	The USPSTF recommends screening adults for depression when staff-assisted depression care supports are in place to assure accurate diagnosis, effective treatment, and follow-up.
Diabetes screening	The USPSTF recommends screening for abnormal blood glucose as part of cardiovascular risk assessment in adults aged 40 to 70 years who are overweight or obese. Clinicians should offer or refer patients with abnormal blood glucose to intensive behavioral counseling interventions to promote a healthful diet and physical activity.
Gestational diabetes mellitus screening	The USPSTF recommends screening for gestational diabetes mellitus in asymptomatic pregnant women after 24 weeks of gestation.
Gonorrhea screening: women	The USPSTF recommends screening for gonorrhea in sexually active women age 24 years or younger and in older women who are at increased risk for infection.
Hearing loss screening: newborns	The USPSTF recommends screening for hearing loss in all newborn infants.
Hemoglobinopathies screening: newborns	The USPSTF recommends screening for sickle cell disease in newborns.
Hepatitis B screening: nonpregnant adolescents and adults	The USPSTF recommends screening for hepatitis B virus infection in persons at high risk for infection.
Hepatitis B screening: pregnant women	The USPSTF strongly recommends screening for hepatitis B virus infection in pregnant women at their first prenatal visit.
Hepatitis C virus infection screening: adults	The USPSTF recommends screening for hepatitis C virus (HCV) infection in persons at high risk for infection. The USPSTF also recommends offering one-time screening for HCV infection to adults born between 1945 and 1965.
High blood pressure in adults: screening	The USPSTF recommends screening for high blood pressure in adults aged 18 years or older. The USPSTF recommends obtaining measurements outside of the clinical setting for diagnostic confirmation before starting treatment.
HIV screening: nonpregnant adolescents and adults	The USPSTF recommends that clinicians screen for HIV infection in adolescents and adults ages 15 to 65 years. Younger adolescents and older adults who are at increased risk should also be screened.
HIV screening: pregnant women	The USPSTF recommends that clinicians screen all pregnant women for HIV, including those who present in labor who are untested and whose HIV status is unknown.
Hypothyrodism screening: newborns	The USPSTF recommends screening for congenital hypothyroidism in newborns.

Intimate partner violence screening: women of childbearing age	The USPSTF recommends that clinicians screen women of childbearing age for intimate partner violence, such as domestic violence, and provide or refer women who screen positive to intervention services. This recommendation applies to women who do not have signs or symptoms of abuse.
Lung cancer screening	The USPSTF recommends annual screening for lung cancer with low-dose computed tomography in adults ages 55 to 80 years who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years. Screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery.
Obesity screening and counseling: adults	The USPSTF recommends screening all adults for obesity. Clinicians should offer or refer patients with a body mass index of 30 kg/m^2 or higher to intensive, multicomponent behavioral interventions.
Obesity screening and counseling: children	The USPSTF recommends that clinicians screen children age 6 years and older for obesity and offer them or refer them to comprehensive, intensive behavioral interventions to promote improvement in weight status.
Osteoporosis screening: women	The USPSTF recommends screening for osteoporosis in women age 65 years and older and in younger women whose fracture risk is equal to or greater than that of a 65-year-old white woman who has no additional risk factors.
Phenylketonuria screening: newborns	The USPSTF recommends screening for phenylketonuria in newborns.
Rh incompatibility screening: first pregnancy visit	The USPSTF strongly recommends Rh (D) blood typing and antibody testing for all pregnant women during their first visit for pregnancy-related care.
Rh incompatibility screening: 24–28 weeks' gestation	The USPSTF recommends repeated Rh (D) antibody testing for all unsensitized Rh (D)-negative women at 24 to 28 weeks' gestation, unless the biological father is known to be Rh (D)-negative.
Syphilis screening: nonpregnant persons	The USPSTF strongly recommends that clinicians screen persons at increased risk for syphilis infection.
Syphilis screening: pregnant women	The USPSTF recommends that clinicians screen all pregnant women for syphilis infection.
Visual acuity screening in children	The USPSTF recommends vision screening for all children at least once between the ages of 3 and 5 years, to detect the presence of amblyopia or its risk factors.

- Have **NOT** been submitted to other PPSs for payment.

Model 3

NYS Defined Information (cannot be changed or altered)

Project Title	Integration of primary care and behavioral health services
Actively Engaged Definition	The total number of patients screened using the PHQ-2 or 9/SBIRT.
Counting Criteria	A count of patients who meet the criteria over a 1-year measurement period. Duplicate counts of patients are not allowed. The count is not additive across DSRIP years.
Data Source	EHRs or other IT Platforms (i.e. patient registries).

Clarifying Information:

- Patients for this project will only count as actively engaged if they receive either a PHQ-2 or 9 or SBIRT screenings.
- All five principals of the IMPACT model must be in place for a site to count.
- Any staffer working within the IMPACT model who is qualified to perform a preventive care screening as required within the project can do so.
- Appropriate screenings would only count if the PCP or the clinical staff is provided the results of the screen and they are incorporated into the medical record.

CNYCC Defined Details:

In order to be considered actively engaged by definitions set by CNYCC, Medicaid members must:

- Have traditional Medicaid, be dually eligible for Medicaid and Medicare, or be a member of Medicaid Managed Care (e.g. Fidelis, Total Care or United Healthcare) **AND**
- Screened using the screenings listed below **AND**

Screened for:	**Screen Used:**
Depression/Suicide	PHQ-2/PHQ-9/A (depression, adults/adolescents)
Substance Use/Abuse Inc. Tobacco	Audit C – for Alcohol ASSIST DAST-10

- Have **NOT** been submitted to other PPSs for payment.

Data Reporting Requirements (all Models)

The data reporting requirements set forth in this appendix apply solely to the Behavioral Health/Primary Care Integration project (3ai) regarding Medicaid Members who are considered actively engaged by the definitions and details stated above.

Data Elements
Partners shall report the following data elements to CNYCC with the frequency set forth below:

- **Patient Last Name**
- **Patient First Name**
- **Client Identification Number (CIN) or Medicaid Managed Care Subscriber ID**
- **Date of Encounter**
- **Screen Performed – enter multiple screens if applicable**

In addition to the information (data elements) that is reported to CNYCC, Partners must retain the following information in the event of an audit.

- **Full Name of Patient who participated in Model 1, Model 2 or Model 3 Behavioral Health/Primary Care Integration**
- **Eligibility Status (Medicaid or Medicaid Managed Care, Services received, screenings performed)**
- **Current Address (if reported)**
- **Current Phone Number (if reported)**
- **Current Email Address (if reported)**
- **Dates of any additional encounters or follow-up with Medicaid Member**

Reporting Schedule
Partners shall report the number of actively engaged patients each Monday for the previous week. For example: On Monday, February 15th, partners are responsible for submitting patient engagement numbers for Monday, February 8th to Sunday, February 14th.

CNYCC has contracted with a Project Management software vendor who is developing a webform for each organization. Once the webform has been finalized and deployed, partners will be responsible for entering actively engaged numbers patients on Mondays for the week prior; the webform will be sent automatically each week.

On the first Monday of a new month, partners are responsible for uploading a Member Roster file that includes the data elements that were defined above for all engaged patients for the previous month. In order to send the file, partners must utilize CNYCC's Secure File Transfer Protocol (SFTP) Site. Instructions for site use, usernames and passwords will be distributed to individuals identified by Partner Organizations; this information will be sent separately.

Partners will be sent an excel template that they can use to create their rosters for data submission. The file naming convention should be*: 3ai Date Parent Organization Name Actively Engaged Patient Roster*. Please do not send a cumulative patient roster; each month submitted should have unique patients.

❒ My organization is an eligible, *safety net* partner organization and intends to fulfill necessary project activities in pursuit of this project payment type through a subcontract with organization: _____, under:

- ❒ Model 1: Integration of Behavioral Health Services in the Primary Care Setting
  - Number of participating, distinct primary care sites within subcontracted partner organization: _____.
    Please list: _____.
- ❒ Model 2: Integration of Primary Care Services in the Behavioral Health Setting
  - Number of participating, distinct behavioral health sites within subcontracted partner organization: _____.
    Please list: _____.
- ❒ Model 3: IMPACT Model (Depression Care Management in the Primary Care Setting)
  - Number of participating, distinct primary care sites within subcontracted partner organization: _____.
    Please list: _____.

❒ My organization, although an eligible, *safety net* partner organization, **does NOT** intend to undertake necessary project activities in pursuit of this project payment type

❒ My organization is an eligible, *non-safety net* partner organization and intends to independently undertake necessary project activities in pursuit of this project payment type, understanding that the amount of funding available to non-safety net participants in aggregate is limited to 5% of the total project valuation, under:

- ❒ Model 1: Integration of Behavioral Health Services in the Primary Care Setting
  - Number of participating, distinct primary care sites within contracting partner organization: _____.
    Please list: _____.
- ❒ Model 2: Integration of Primary Care Services in the Behavioral Health Setting
  - Number of participating, distinct behavioral health sites within contracting partner organization: _____.
    Please list: _____.
- ❒ Model 3: IMPACT Model (Depression Care Management in the Primary Care Setting)
  - Number of participating, distinct primary care sites within contracting partner organization: _____.
    Please list: _____.

❒ My organization is an eligible, *non-safety net* partner organization and intends to undertake necessary project activities in pursuit of this project payment type as a subcontractor of organization: _____, an eligible, *safety net* partner organization

❒ My organization, although an eligible, *non-safety net* partner organization, **does NOT** intend to undertake necessary project activities in pursuit of this project payment type

❒ My organization is not an eligible partner organization of any type above

- Total Amount Available for DY1 Payments: $757,601
- Payment Amount Calculation: Total equally divided by number of participating sites
- Estimated Average Payment Per Partner: Assuming 125 participating sites, $6,060.81 per site
- Additional Payment Stipulations:
  - Partner organizations will complete and submit a site-specific project implementation plan to include:
    1. An articulation of the organization's current state and how the organization plans to meet project requirements, given current state.
    2. The plan for adoption of PPS-wide protocols and screenings, when identified.
    3. A non-binding estimate of the organization's annual patient engagement under this project.
    4. An articulation of the organization's current capacity to monitor performance and implement improvements internally and a plan to monitor performance and implement improvements under this project.
    5. An articulation of the organization's sustainability plan for new elements implemented under this project.
    6. An articulation of initial thinking about integration workflows: who does screening, how are results shared with patient/care team, what happens with positive screen/negative screen, frequency of screen, and where are screen results documented
    7. An articulation of how current staff will be used under this project and a plan for additional hiring needed (include credentialing needed, services to be provided by individual).
    8. Identification of key external partners that will be critical to meeting project requirements.
    9. Signatures: Plan should be signed by those who have direct authority over implementation.

Payment Mechanism 3: Lump sum payments for implementation of site-specific project implementation plans

- Eligible Partner Organizations: Behavioral health organizations and organizations that provide primary care that intend to provide integrated primary care/behavioral health services under Project 3ai Model 1, Model 2, and/or Model 3

❒ My organization is an eligible, *safety net* partner organization and intends to undertake necessary project activities in pursuit of this project payment type under:

❒ Model 1: Integration of Behavioral Health Services in the Primary Care Setting
- Number of participating, distinct primary care sites within contracting partner organization: _____.
  Please list: _____.

❒ Model 2: Integration of Primary Care Services in the Behavioral Health Setting
- Number of participating, distinct behavioral health sites within contracting partner organization: _____.
  Please list: _____.

❒ Model 3: IMPACT Model (Depression Care Management in the Primary Care Setting)
- Number of participating, distinct primary care sites within contracting partner organization: _____.
  Please list: _____.

❒ My organization is an eligible, *safety net* partner organization and intends to fulfill necessary project activities in pursuit of this project payment type through a subcontract with organization: _____, under:

❒ Model 1: Integration of Behavioral Health Services in the Primary Care Setting
- Number of participating, distinct primary care sites within subcontracted partner organization: _____.
  Please list: _____.

❒ Model 2: Integration of Primary Care Services in the Behavioral Health Setting
- Number of participating, distinct behavioral health sites within subcontracted partner organization: _____.
  Please list: _____.

❒ Model 3: IMPACT Model (Depression Care Management in the Primary Care Setting)

- Number of participating, distinct primary care sites within subcontracted partner organization: _____.
  Please list: _____.

❒ My organization, although an eligible, *safety net* partner organization, **does NOT** intend to undertake necessary project activities in pursuit of this project payment type

❒ My organization is an eligible, *non-safety net* partner organization and intends to independently undertake necessary project activities in pursuit of this project payment type, understanding that the amount of funding available to non-safety net participants in aggregate is limited to 5% of the total project valuation, under:

❒ Model 1: Integration of Behavioral Health Services in the Primary Care Setting
- Number of participating, distinct primary care sites within contracting partner organization: _____.
  Please list: _____.

❒ Model 2: Integration of Primary Care Services in the Behavioral Health Setting
- Number of participating, distinct behavioral health sites within contracting partner organization: _____.
  Please list: _____.

❒ Model 3: IMPACT Model (Depression Care Management in the Primary Care Setting)
- Number of participating, distinct primary care sites within contracting partner organization: _____.
  Please list: _____.

❒ My organization is an eligible, *non-safety net* partner organization and intends to undertake necessary project activities in pursuit of this project payment type as a subcontractor of organization: _____, an eligible, *safety net* partner organization

❒ My organization, although an eligible, *non-safety net* partner organization, **does NOT** intend to undertake necessary project activities in pursuit of this project payment type

❒ My organization is not an eligible partner organization of any type above

- Total Amount Available for DY1 Payments: $ 1,948,117
- Payment Amount Calculation: 50% of funds dispersed equally with the remaining 50% scaled (e.g., number of providers, annual visits, etc.)
- Estimated Average Payment Per Partner: Assuming 125 participating sites, an average $15,585 per site

Project Requirement Criteria – Exhibit C

Project: Behavioral Health/Primary Care Integration (3.a.i)

Model 1

NYS Defined Information (cannot be changed or altered)

Project Title	Integration of primary care and behavioral health services
Actively Engaged Definition	The total number of patients receiving appropriate preventive care screenings that include mental/substance abuse.
Counting Criteria	A count of patients who meet the criteria over a 1-year measurement period. Duplicate counts of patients are not allowed. The count is not additive across DSRIP years.
Data Source	EHRs or other IT Platforms (i.e. patient registries).

Clarifying Information:

- The PPS is expected to utilize the preventative care screening based on nationally-accepted best practices determined to be age-appropriate.
- Any staffer working at a PCMH/APCM Service Site who is qualified to perform a preventive care screening can do so. However, preventive care screenings conducted with a patient via telepsychiatry alone will not count within this active engagement definition.
- Appropriate screenings would only count if the PCP or the clinical staff is provided the results of the screen and they are incorporated into the medical record.
- The expectation of co-located primary care-behavioral health site is that there is a licensed behavioral health provider on site engaged in the practice.

CNYCC Defined Details:

In order to be considered actively engaged by definitions set by CNYCC, Medicaid members must:

- Have traditional Medicaid, be dually eligible for Medicaid and Medicare, or be a member of Medicaid Managed Care (e.g. Fidelis, Total Care or United Healthcare) **AND**
- Have received the appropriate preventive care screenings that include mental/substance abuse from the table below **AND**

Screened For:	**Screen Used:**

Depression/Suicide	PHQ-2/PHQ-9/A (depression, adults/adolescents) Edinburgh scale (postpartum depression) CES-DC (Depression Scale for Children) (ages 6-17 yr) Columbia Rating Scale (suicide, children up to adults) Zung-Self Rated Depression Scale Modified Mini Screen (Depression and Anxiety) Mood and Feelings Questionnaire (ages 8-18)
Anxiety	GAD-7 (anxiety, children, adults) SCARED (children, parents) Modified Mini Screen (Depression and Anxiety) PSWQ (youth)
Bipolar disorder	Young Mania Rating Scale (youth) Child Mania Rating Scale-Parent (parent of youth)
Substance Use/Abuse Including Tobacco	CRAFFT (substance abuse, 12-18 yrs) MSSI (substance abuse, adults) CAGE SSI-AOD Simple Screening Instrument for Alcohol and Other Drugs Audit C – for Alcohol ASSIST DAST-10
Social/Emotional/Psychosocial	ASQ-SE (social-emotional, ages at stages, 6 mos to 5 yrs) SDQ-2 (strengths and difficulties, 6-16 yrs) Pediatric Symptom Checklist (Children) Strengths and Difficulties Questionnaires (Children) Modified Overt Aggression Scale (MOAS; clinician rating) MOAS (retrospective; parent) Nisonger Child Behavior Rating Form (CBRF long; parent) Outburst Monitoring Scale NEW
ADHD	Edelbrock Rating Scale Vanderbilt Parent Rating ADHD Rating Scale (adults)
Autism	Modified CHAT (M-CHAT; parent) M-CHAT Follow Up
Eating Disorders	Eating Attitude Test BULIT-R

- Have **NOT** been submitted to other PPSs for payment.

Model 2

NYS Defined Information (cannot be changed or altered)

Project Title	Integration of primary care and behavioral health services
Actively Engaged Definition	The total number of patients receiving primary care services at a participating mental health or substance abuse site.
Counting Criteria	A count of patients who meet the criteria over a 1-year measurement period. Duplicate counts of patients are not allowed. The count is not additive across DSRIP years.
Data Source	EHRs or other IT Platforms (i.e. patient registries).

Clarifying Information:

- Primary Care Services are defined as preventive care screenings billed through Current Procedural Terminology (CPT) codes.
- The mental health are substance abuse sites have to be Partners in the Network Tool in order to count.
- Any staffer working at a Behavioral Health Site who is qualified to perform a preventive care screening as required within the project can do so.
- Appropriate screenings would only count if the PCP or the clinical staff is provided the results of the screen and they are incorporated into the medical record.
- The only types of "primary care providers" that may be utilized to provide primary care services within the BH site are participating PCPs, NPs and physician assistants working closely with a PCP.

CNYCC Defined Details:

In order to be considered actively engaged by definitions set by CNYCC, Medicaid members must:

- Have traditional Medicaid, be dually eligible for Medicaid and Medicare, or be a member of Medicaid Managed Care (e.g. Fidelis, Total Care or United Healthcare) **AND**
- Have received primary care services from the list below at a participating mental health or substance abuse sites **AND**

Topic	**Description**
Abdominal aortic aneurysm screening: men	The USPSTF recommends one-time screening for abdominal aortic aneurysm by ultrasonography in men ages 65 to 75 years who have ever smoked.
Alcohol misuse: screening and counseling	The USPSTF recommends that clinicians screen adults age 18 years or older for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse.
Bacteriuria screening: pregnant women	The USPSTF recommends screening for asymptomatic bacteriuria with urine culture in pregnant women at 12 to 16 weeks' gestation or at the first prenatal visit, if later.

Blood pressure screening in adults	The USPSTF recommends screening for high blood pressure in adults aged 18 years or older. The USPSTF recommends obtaining measurements outside of the clinical setting for diagnostic confirmation before starting treatment.
BRCA risk assessment and genetic counseling/testing	The USPSTF recommends that primary care providers screen women who have family members with breast, ovarian, tubal, or peritoneal cancer with one of several screening tools designed to identify a family history that may be associated with an increased risk for potentially harmful mutations in breast cancer susceptibility genes (*BRCA1* or *BRCA2*). Women with positive screening results should receive genetic counseling and, if indicated after counseling, BRCA testing.
Breast cancer screening	The USPSTF recommends screening mammography for women, with or without clinical breast examination, every 1 to 2 years for women age 40 years and older.
Cervical cancer screening	The USPSTF recommends screening for cervical cancer in women ages 21 to 65 years with cytology (Pap smear) every 3 years or, for women ages 30 to 65 years who want to lengthen the screening interval, screening with a combination of cytology and human papillomavirus (HPV) testing every 5 years.
Chlamydia screening: women	The USPSTF recommends screening for chlamydia in sexually active women age 24 years or younger and in older women who are at increased risk for infection.
Cholesterol abnormalities screening: men 35 and older	The USPSTF strongly recommends screening men age 35 years and older for lipid disorders.
Cholesterol abnormalities screening: men younger than 35	The USPSTF recommends screening men ages 20 to 35 years for lipid disorders if they are at increased risk for coronary heart disease.
Cholesterol abnormalities screening: women 45 and older	The USPSTF strongly recommends screening women age 45 years and older for lipid disorders if they are at increased risk for coronary heart disease.
Cholesterol abnormalities screening: women younger than 45	The USPSTF recommends screening women ages 20 to 45 years for lipid disorders if they are at increased risk for coronary heart disease.
Colorectal cancer screening	The USPSTF recommends screening for colorectal cancer using fecal occult blood testing, sigmoidoscopy, or colonoscopy in adults beginning at age 50 years and continuing until age 75 years. The risks and benefits of these screening methods vary.
Depression screening: adolescents	The USPSTF recommends screening adolescents (ages 12-18 years) for major depressive disorder when systems are in place to ensure accurate diagnosis, psychotherapy (cognitive-behavioral or interpersonal), and follow-up.

Depression screening: adults	The USPSTF recommends screening adults for depression when staff-assisted depression care supports are in place to assure accurate diagnosis, effective treatment, and follow-up.
Diabetes screening	The USPSTF recommends screening for abnormal blood glucose as part of cardiovascular risk assessment in adults aged 40 to 70 years who are overweight or obese. Clinicians should offer or refer patients with abnormal blood glucose to intensive behavioral counseling interventions to promote a healthful diet and physical activity.
Gestational diabetes mellitus screening	The USPSTF recommends screening for gestational diabetes mellitus in asymptomatic pregnant women after 24 weeks of gestation.
Gonorrhea screening: women	The USPSTF recommends screening for gonorrhea in sexually active women age 24 years or younger and in older women who are at increased risk for infection.
Hearing loss screening: newborns	The USPSTF recommends screening for hearing loss in all newborn infants.
Hemoglobinopathies screening: newborns	The USPSTF recommends screening for sickle cell disease in newborns.
Hepatitis B screening: nonpregnant adolescents and adults	The USPSTF recommends screening for hepatitis B virus infection in persons at high risk for infection.
Hepatitis B screening: pregnant women	The USPSTF strongly recommends screening for hepatitis B virus infection in pregnant women at their first prenatal visit.
Hepatitis C virus infection screening: adults	The USPSTF recommends screening for hepatitis C virus (HCV) infection in persons at high risk for infection. The USPSTF also recommends offering one-time screening for HCV infection to adults born between 1945 and 1965.
High blood pressure in adults: screening	The USPSTF recommends screening for high blood pressure in adults aged 18 years or older. The USPSTF recommends obtaining measurements outside of the clinical setting for diagnostic confirmation before starting treatment.
HIV screening: nonpregnant adolescents and adults	The USPSTF recommends that clinicians screen for HIV infection in adolescents and adults ages 15 to 65 years. Younger adolescents and older adults who are at increased risk should also be screened.
HIV screening: pregnant women	The USPSTF recommends that clinicians screen all pregnant women for HIV, including those who present in labor who are untested and whose HIV status is unknown.
Hypothyrodism screening: newborns	The USPSTF recommends screening for congenital hypothyroidism in newborns.

Intimate partner violence screening: women of childbearing age	The USPSTF recommends that clinicians screen women of childbearing age for intimate partner violence, such as domestic violence, and provide or refer women who screen positive to intervention services. This recommendation applies to women who do not have signs or symptoms of abuse.
Lung cancer screening	The USPSTF recommends annual screening for lung cancer with low-dose computed tomography in adults ages 55 to 80 years who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years. Screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery.
Obesity screening and counseling: adults	The USPSTF recommends screening all adults for obesity. Clinicians should offer or refer patients with a body mass index of 30 kg/m^2 or higher to intensive, multicomponent behavioral interventions.
Obesity screening and counseling: children	The USPSTF recommends that clinicians screen children age 6 years and older for obesity and offer them or refer them to comprehensive, intensive behavioral interventions to promote improvement in weight status.
Osteoporosis screening: women	The USPSTF recommends screening for osteoporosis in women age 65 years and older and in younger women whose fracture risk is equal to or greater than that of a 65-year-old white woman who has no additional risk factors.
Phenylketonuria screening: newborns	The USPSTF recommends screening for phenylketonuria in newborns.
Rh incompatibility screening: first pregnancy visit	The USPSTF strongly recommends Rh (D) blood typing and antibody testing for all pregnant women during their first visit for pregnancy-related care.
Rh incompatibility screening: 24–28 weeks' gestation	The USPSTF recommends repeated Rh (D) antibody testing for all unsensitized Rh (D)-negative women at 24 to 28 weeks' gestation, unless the biological father is known to be Rh (D)-negative.
Syphilis screening: nonpregnant persons	The USPSTF strongly recommends that clinicians screen persons at increased risk for syphilis infection.
Syphilis screening: pregnant women	The USPSTF recommends that clinicians screen all pregnant women for syphilis infection.
Visual acuity screening in children	The USPSTF recommends vision screening for all children at least once between the ages of 3 and 5 years, to detect the presence of amblyopia or its risk factors.

- Have **NOT** been submitted to other PPSs for payment.

Model 3

NYS Defined Information (cannot be changed or altered)

Project Title	Integration of primary care and behavioral health services
Actively Engaged Definition	The total number of patients screened using the PHQ-2 or 9/SBIRT.
Counting Criteria	A count of patients who meet the criteria over a 1-year measurement period. Duplicate counts of patients are not allowed. The count is not additive across DSRIP years.
Data Source	EHRs or other IT Platforms (i.e. patient registries).

Clarifying Information:

- Patients for this project will only count as actively engaged if they receive either a PHQ-2 or 9 or SBIRT screenings.
- All five principals of the IMPACT model must be in place for a site to count.
- Any staffer working within the IMPACT model who is qualified to perform a preventive care screening as required within the project can do so.
- Appropriate screenings would only count if the PCP or the clinical staff is provided the results of the screen and they are incorporated into the medical record.

CNYCC Defined Details:

In order to be considered actively engaged by definitions set by CNYCC, Medicaid members must:

- Have traditional Medicaid, be dually eligible for Medicaid and Medicare, or be a member of Medicaid Managed Care (e.g. Fidelis, Total Care or United Healthcare) **AND**
- Screened using the screenings listed below **AND**

Screened for:	**Screen Used:**
Depression/Suicide	PHQ-2/PHQ-9/A (depression, adults/adolescents)
Substance Use/Abuse Inc. Tobacco	Audit C – for Alcohol ASSIST DAST-10

- Have **NOT** been submitted to other PPSs for payment.

Data Reporting Requirements (all Models)

The data reporting requirements set forth in this appendix apply solely to the Behavioral Health/Primary Care Integration project (3ai) regarding Medicaid Members who are considered actively engaged by the definitions and details stated above.

Data Elements
Partners shall report the following data elements to CNYCC with the frequency set forth below:

- **Patient Last Name**
- **Patient First Name**
- **Client Identification Number (CIN) or Medicaid Managed Care Subscriber ID**
- **Date of Encounter**
- **Screen Performed – enter multiple screens if applicable**

In addition to the information (data elements) that is reported to CNYCC, Partners must retain the following information in the event of an audit.

- **Full Name of Patient who participated in Model 1, Model 2 or Model 3 Behavioral Health/Primary Care Integration**
- **Eligibility Status (Medicaid or Medicaid Managed Care, Services received, screenings performed)**
- **Current Address (if reported)**
- **Current Phone Number (if reported)**
- **Current Email Address (if reported)**
- **Dates of any additional encounters or follow-up with Medicaid Member**

Reporting Schedule
Partners shall report the number of actively engaged patients each Monday for the previous week. For example: On Monday, February 15th, partners are responsible for submitting patient engagement numbers for Monday, February 8th to Sunday, February 14th.

CNYCC has contracted with a Project Management software vendor who is developing a webform for each organization. Once the webform has been finalized and deployed, partners will be responsible for entering actively engaged numbers patients on Mondays for the week prior; the webform will be sent automatically each week.

On the first Monday of a new month, partners are responsible for uploading a Member Roster file that includes the data elements that were defined above for all engaged patients for the previous month. In order to send the file, partners must utilize CNYCC's Secure File Transfer Protocol (SFTP) Site. Instructions for site use, usernames and passwords will be distributed to individuals identified by Partner Organizations; this information will be sent separately.

Partners will be sent an excel template that they can use to create their rosters for data submission. The file naming convention should be*: 3ai Date Parent Organization Name Actively Engaged Patient Roster*. Please do not send a cumulative patient roster; each month submitted should have unique patients.