CBHS IPA Secures Funding for Lower Hudson Valley Adults

By Richard M. Tuten, JD, MSA
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Cordinated Behavioral Health Services (CBHS) Independent Practice Association (IPA) is pleased to announce it has been awarded $4.7 million in infrastructure funds to finance the enhancement of Behavioral Health Home and Community Based Services (HCBS) available in the Hudson Valley.

HCBS services are designed to help individuals with significant behavioral health disorders achieve their personal goals, specifically achieving greater independence, enhancing their education, gaining and maintaining employment, accessing support from peers and for their families, and managing crises.

CBHS has entered into agreements with four health plans to improve access and increase utilization of HCBS for Medicaid recipients. Medicaid members enrolled in Health and Recovery Plans (HARP), which are specialized plans for Medicaid recipients with serious mental illnesses or significant substance use disorders. CBHS looks forward to its partnership with Fidelis, MVP, Affinity, and UnitedHealthcare to make critical investments that will lead to enhancements throughout the region for individuals who are eligible for HCBS.

CBHS will be funding projects related to workforce development, peer support development, and outreach and education. Funds will also be used to increase access to crisis and respite services.

The New York State Office of Mental Health made a total of $50 million available to address changes in the delivery of services necessitated by access to these newly launched services are able to access them easily, efficiently, and quickly. We look forward to collaborating with our managed care service organization partners to drive the success of this initiative,” said CBHS CEO Richard Tuten, “HCBS can make a huge difference in people’s lives, but only if they have access to them. That’s why we think these newly awarded funds will be so important to our community.”

“CBHS is pleased to announce it has been awarded $4.7 million in infrastructure funds to finance the enhancement of Behavioral Health Home and Community Based Services (HCBS) available in the Lower Hudson Valley Region. This critical funding will help CBHS ensure that residents of the lower Hudson Valley have access to these newly launched services. CBHS, founded in 2012, is developing business initiatives to successfully integrate and manage care and provide the cost-effective outcome-based services required for the future. Our commitment is to promote health and wellness, to facilitate the attainment of life roles in the areas of employment, housing, and social connectedness; to ensure access for whole populations, to ensure satisfaction from the people we serve and their families; and to do so at sustainable costs. CBHS Inc is the sole member of CBHS IPA, LLC for further information, please contact: Richard Tuten, by phone (914) 703-0453 or by Email at tutenr@cbhsinc.org.

Integrating Peers within Behavioral Health Programs


The implementation of peer support professionals throughout the behavioral health field has proven to be a valuable resource for clients, patients, and specialized clinical providers across the continuum (SAMHSA, Value of Peers, 2017). Whether it be in an outpatient clinic, emergency room, or community setting, peer professionals trained to work with substance use disorder (SUD) populations have brought a unique perspective to support patients on their journeys to recovery. Staten Island (SI), a borough within NYC, which has a population of nearly 476,000, has been one of the epicenters of the opioid epidemic. From 2015 to 2018, there were 383 fatal overdoses on SI, according to the Office of the Richmond County District Attorney. SI overdose rates, as determined by the NYC department of health, were higher than the other NYC boroughs until 2017. Although Staten Island has a strong network of treatment providers and harm reduction services, consistently high rates of overdose indicate the need for creative client engagement and non-traditional approaches. Peer models quickly emerged as a promising method to address this issue, but SI has been lacking a sustainable peer workforce.

In 2015, the Behavioral Health Infrastructure Project (BHIP), spearheaded by the Staten Island Partnership for Community Wellness (SIPCW) and the SI Performing Provider System (SI PPP), was established to build multi-sectoral partners together to build the capacity of systems to address the unique behavioral health needs of the community. Early on, BHIP worked to identify gaps in the behavioral health continuum and surfaced peers as a component to bolster the infrastructure. Through a mixture of DRIP innovation dollars and OASAS grants, opportunities were created to increase the supply and demand for the peer workforce. Through many local efforts including the development of the SI CUNY and SI PPP Certified Recovery Peer Advocate (CRPA) curriculum, SI PPP scholarships and salary grants, the expansion of OASAS reimbursement criteria, and local and state grants to integrate peer positions, the number of peers on Staten Island has been steadily increasing. Within the past few years, there has been an increase from only two CRPAs in 2015 to 30 new CRPAs in 2018 on Staten Island. It is important to note that other types of substance use treatment and mental health peers exist in the community that are contributing to the pool of qualified professionals providing peer services in addition to CRPAs.

Through BHIP, SIPCW and the SI PPP have been working with behavioral health providers to support recruitment, onsite orientations and training, and workflow improvements to help integrate peers into the provider’s system. A peer is a client who is able to meet with a client throughout the recovery process. Peers have been working with behavioral health providers to help connect clients to community resources and, most importantly, to build trust and rapport. Peers engage clients who are on waiting lists for treatment or by email at tutenr@cbhsnc.org.
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not see the patient face to face or pre-
scribe medications. The psychiatric con-
sultant is not required to be a participating
Medicare provider because payment for the
CoCM service is made directly to the
billing provider (the treating physician or
other qualified health care professional).

The behavioral health manager and the
psychiatric consultant may or may not be
employees of the same practice as the
billing provider and may be independent
contractors hired by the billing practice.
The behavioral health manager must be
available to provide face to face services
if needed, but the psychiatric consultant is
often located remotely.

Available Codes

Code 99492, the code for initial psy-
chiatric collaborative care management, is
described as follows:

99492 Initial psychiatric collabora-
tive care management, first 70 minutes
in the first calendar month of behavioral
health care manager activities, in consul-
tation with a psychiatric consultation, and
directed by the treating physician or other
qualified health care professional, with
the following required elements:

• outreach to and engagement in treat-
ment of a patient directed by the treating
physician or other qualified health care
professional;

• initial assessment of the patient, includ-
ing administration of validated rating
scales, with the development of an indi-

gualized treatment plan

• review by the psychiatric consultant with
modifications of the plan if recommended;

• entering patient in a registry and track-
ing patient follow-up and progress using
the registry, with appropriate documenta-
tion, and participation in weekly caseload
consultation with the psychiatric consult-
ant; and

• provision of brief interventions using
evidence-based techniques such as behav-
ioral activation, motivational interviewing,
and other focused treatment strategies.

Code 99493 is used for reporting the
first 60 minutes of subsequent psychiatric
collaborative care management during a
subsequent month of behavioral health
care manager activities. This code is gen-

erally used for reporting follow up activi-
ties, including patient tracking, weekly
caseload consultation, and ongoing col-
aboration, coordination and monitoring.

Code 99494 is an add-on code for addi-
tional 30-minute periods of either initial
or subsequent care management.

CMS has also approved a general care
management code (99484), which may be
used for integrated services provided
without a specific behavioral health care
manager. 99484 provides for at least 20
minutes of care management services for
behavioral health conditions per calendar
month, including assessment, monitoring,

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integrated into workplace operations.

While there are various ways that a peer
can provide support services, the unique
lived experience that they bring to any
service provider is invaluable, whether it
be modeling coping skills, raising aware-
ness of existing support services, or edu-
cating clients about various modes of
substance use disorder. By continuing to
provide and expand this service, individu-
als living with SUD can have an advocate
who emphasizes knowledge and wisdom
through their lived experience as they
work towards the ultimate goal of recov-
ery. While there remains a gap in connect-
ing certified peers to available positions in
the community, new funding acquired by
SI PPS from HRSA, will allow the Staten
Island community to continue to tackle
this challenge by ensuring peers are
trained to meet the specific needs of local
programs.

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For more information, please visit

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In exciting breaking news, in late
August, 2019, Illinois became the first
state to enact the APA’s model collabora-
tive care legislation into law. Illinois bill
SB 2085, Psychiatric Collaborative Care,
statute requires private insurers in Illinois
as well as the Illinois Medicaid program
to provide reimbursement for the CoCM
CPT codes.

Hopefully, other states will follow suit
in the near term, allowing for greater im-
plementation of behavioral health integra-
tion among primary care services. In order
to fully implement integrated care into our
health system, we must have the full sup-
port of all third party payers, including
government and private carriers. Without
adequate reimbursement, integrated care
models cannot be truly successful and the
system will fail short in its goals of im-
proved outcomes, enhanced access and
lowered costs for all.

Rachel A. Fernbach, Esq. is Deputy
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Footnote

1. Medicare Payment for Behavioral
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