Hospital Discharge Planning Initiative
Program Guidance for NYS BH IPAs

March 22, 2024

A. Introduction and Overview

This guidance provides information to Behavioral Health Independent Practice Associations (BH IPAs) participating in the New York State (NYS) Hospital Discharge Planning Initiative. This initiative represents an opportunity for NYS Office of Mental Health (OMH) and Office of Addiction Services and Supports (OASAS) to leverage BH IPAs to address NYS priorities. This will be the final round of State funding for the BH IPAs. The intention of this funding is to assist with the NYS Governor's priority to improve hospital discharge planning for high-risk individuals with mental health or addiction needs and establish systemic accountability to ensure these individuals receive immediate access to outpatient mental health or addiction services while also assisting BH IPAs with sustainability through this final round of funding.

B. Application and Awards

I. Application

BH IPAs must respond to the Hospital Discharge Planning Initiative notification by completing and submitting the State-provided application by **May 3, 2024.** Applications should be submitted to the NYS VBP Readiness Mailbox: VBP-Readiness@omh.ny.gov.

BH IPAs may apply individually or as a group of two or more BH IPAs. Group collaborations may span more than one OMH field office region. BH IPAs which do not qualify to participate individually may apply for this initiative as part of a group.

BH IPAs must meet or exceed a NYS-defined minimum Medicaid managed care recipient attribution threshold of 15,000 to participate and may apply as a group to do so. To be included in the attribution, Medicaid managed care members must receive at least one children or adult behavioral health service listed below from a BH IPA's network provider. Applications (individual or joint) below the final NYS-defined threshold will not be funded. BH IPAs that do not meet this minimum threshold are encouraged to partner with other BH IPAs in order to do so.

II. Awards

Awards will be made with consideration of statewide coverage. Award amounts are determined using a State-defined methodology based on attribution and region. Network program types in multiple BH IPAs must attribute each county to only one BH IPA. Network program types eligible for attribution and included in performance measure evaluation are:

- OMH Personalized Recovery Oriented Services (PROS)
- OMH Partial Hospitalization (PH)
- OMH Mental Health Outpatient Treatment and Rehabilitative Services (MHOTRS)

- OMH Continuing Day Treatment (CDT)
- OMH Children's Day Treatment (DT)
- OMH Assertive Community Treatment (ACT)
- OMH Crisis Intervention Benefit (Mobile Crisis, Crisis Residences, Crisis Stabilization Centers)
- OASAS Residential Stabilization
- OASAS Residential Rehabilitation
- OASAS Residential Rehab Services for Youth (RRSY)
- OASAS Part 822 Outpatient Services
- OASAS Outpatient Rehabilitation
- OASAS Opioid Treatment Program
- OASAS Medically Supervised Outpatient Withdrawal
- OASAS Medically Managed Inpatient Withdrawal
- OASAS Medically Supervised Inpatient Withdrawal
- OASAS Clinic
- OASAS Inpatient Rehabilitation
- Certified Community Behavioral Health Clinic (CCBHC)
- Children's Home and Community Based Services (HCBS)
- Children and Family Treatment and Support Services (CFTSS)
- Adult Behavioral Health Home and Community Based Services (BH HCBS)
- Community Oriented Recovery and Empowerment (CORE) Services

Affiliates are included in this application to demonstrate working relationships needed to support community tenure of individuals after hospital discharge. These entities are not eligible for attribution nor included in performance measure evaluation. Affiliates include specialty mental health care management and health homes, critical time intervention-like programs such as safe option support (SOS) teams, physical health providers, non-Medicaid providers, hospitals, and organizations addressing health-related social needs.

NYS will make this funding available through the Medicaid Managed Care Plans (MMCPs) involved in previous BH IPA initiatives. When applying as a group, one BH IPA must identify as the contracting entity (contracting BH IPA) and will contract with their historical MMCP partner. Funds will flow from the MMCP to the contracting BH IPA, and from the contracting BH IPA to the other BH IPAs in the group. BH IPAs applying individually will contract with their historical MMCP partner. Funding will be received in two installments. Funding may only be retained if performance goal requirements are met.

C. Performance and Time Frames

BH IPAs will be evaluated on improvement of four State-identified performance measures during two six-month performance periods. This initiative will occur between April 1, 2024, and March 31, 2025. BH IPAs will receive the first payment, seventy (70) percent of the total award, after contract execution with the partner MMCP. The second payment of the remaining thirty (30) percent of the award amount will be received following the first performance period. **Funds received may be retained only if performance measurement goals are achieved.** Final performance measurement and fund reconciliation will occur approximately six months after the second performance period ends, as described below.

Using Medicaid paid claims, NYS will track achievement on four performance measures for Medicaid Managed Care (MMC) (Mainstream, Health and Recovery Plan, and HIV-Special Needs Plan) enrollees attributed to the BH IPAs. See *Appendix A: BH IPA Performance Measure Technical Specifications* for definitions.

The four performance metrics are:

- Addiction Domain:
  1. Increase in Opioid Use Disorder (OUD) Medication Initiation
  2. Increase in 7-day follow up after high-intensity care for substance use disorder
- Mental Health Domain:
  3. Increase in 7-day follow up after a mental health hospitalization
  4. Increase in Engagement in Community-Based Mental Health Care After a Mental Health Hospitalization

- **Performance Baseline Period**: 4/1/2023-9/30/2023
- **Performance Period 1 (PP1)**: 4/1/2024-9/30/2024
  - BH IPAs must improve from the baseline period on at least one goal in one domain (mental health or addiction) to retain 70% of the total award.
- **Performance Period 2 (PP2)**: 10/1/2024-3/31/2025
  - BH IPAs must retain progress within a NYS-defined range on at least one PP1 goal **AND** improve or retain progress from PP1 on at least one goal from the other domain (mental health or addiction disorder) to retain remaining 30% of award.
- **Evaluation & Baseline Reconciliation Period**: 4/1/2025-9/30/2025

Performance measures will be evaluated in aggregate across all network program types in the BH IPA, including BH IPAs participating as a group. Please note all criteria and performance calculations will be based on Medicaid claims that have been paid within the State or MCO's required timeframe, per the direct payment template submitted to CMS.

The information provided in the application (agency submission template) will be used to inform attribution for performance evaluation. Payments will be subject to recoupment if performance goals are not attained.

All network agencies that participated in the BH IPA networks during the baseline period, PP1, and PP2 will be included in measure evaluation. If an agency joins a BH IPA, the agency's metrics will be included in the performance and baseline calculations to ensure consistency and comparability across different measurement periods. If an agency leaves the BH IPA, the agency's metrics will be excluded from the performance and baseline calculations to ensure consistency and comparability across different measurement periods. BH IPA network agencies and affiliates must be verifiable on BH IPA websites or by submitting signed letters on network agency or affiliate letterhead. **BH IPAs must submit any network changes to the NYS VBP Readiness Mailbox as soon as possible, no later than March 31, 2025**: VBP-Readiness@omh.ny.gov.

NYS will not provide baseline measurements. NYS will advise BH IPAs of the preliminary results from the first measurement period in early 2025, after the claims runout period. NYS will

determine whether BH IPAs sufficiently attained the performance measurement goals from the first and second performance periods approximately six months after the end of the second performance period. If a BH IPA has not demonstrated attainment, MMCPs will recoup funds as appropriate. A final report detailing processes implemented to achieve success will be required. NYS may issue future guidance on additional reporting requirements.

D. BH IPA Allowable Expenditures

BH IPAs must use the Hospital Discharge Planning Initiative funds within the parameters outlined below.

As described earlier in this guidance, the intention of this funding is to assist with the NYS Governor's priority to improve hospital discharge planning for high-risk individuals with mental health or addiction needs and establish systemic accountability to ensure these individuals receive immediate access to outpatient mental health or addiction services.

BH IPAs can support community-based organizations (CBOs) and hospitals in developing relationships to improve information sharing, facilitate rapid appointment scheduling, and increase access to community-based services upon hospital discharge using behavioral health provider networks and data infrastructure. Funding may be used for quality improvement and implementation activities, like learning collaboratives and workforce training, to help providers achieve these goals.

These funds support individuals and their families to prevent hospital readmission in the first 60 days following discharge. BH IPAs may allocate funds to CBOs and behavioral health providers to facilitate access to outpatient behavioral health and community wrap-around services. For example, CBOs may use allocated funds to address health-related social needs such as transportation or childcare. BH IPAs may use funds to support data sharing, such as enhancements to information technology and connections to NY's Qualified Entities (QEs). BH IPAs can fund ER/CPEP navigators, including peers, to support the member throughout the stay and discharge experience.

E. Expenditure Exclusions

BH IPA funds cannot supplant existing funding streams for staffing but can supplement said funding streams for the purpose of meeting initiative goals.

If a BH IPA receives funding through any other NYS initiative, the BH IPA is responsible for clearly distinguishing allocation of funds to ensure any single expenditure is unduplicated.

Hospital Discharge Planning Initiative

Program Guidance for NYS BH IPAs

Appendix A - BH IPA Performance Measure Technical Specifications

1. Performance Measure Definitions

Performance goals will be measured during two performance periods outlined in Section C. Timeframe.

#	Measure Name	Source/Developer	Numerator	Denominator
I.	Increase[1] in Opioid Use Disorder (OUD) Medication Initiation	QARR measure with modifications	MMC enrollees 18 years and older attributed[2] to a BH IPA who initiated pharmacotherapy treatment within 30 days following an index visit[3] with a diagnosis of opioid dependence.	MMC enrollees 18 years and older attributed[2] to a BH IPA who during the intake period[4] had an index visit with a diagnosis of opioid dependence.
II.	Increase[1] in 7-day Follow-Up After High-Intensity Care for Substance Use Disorder	HEDIS (Link) with modifications	Number of inpatient, residential treatment and detoxification visits or discharges for a diagnosis of Substance Use Disorder (SUD) among MMC enrollees 13 years and older attributed[2] to a BH IPA who had follow-up care for a diagnosis of SUD within 7 days.	Number of inpatient, residential treatment and detoxification visits or discharges for a diagnosis of SUD among MMC enrollees 13 years and older attributed[2] to a BH IPA.
III.	Increase[1] in 7-day Follow-Up After Hospitalization for Mental Illness	HEDIS (Link) with modifications	Number of inpatient discharges with a primary diagnosis of mental illness or intentional self-harm for MMC enrollees (age 6 - 64) attributed[2] to a BH IPA who had a follow-up visit with a mental health provider within 7 days after discharge.	Number of inpatient discharges with a primary diagnosis of mental illness or intentional self-harm for MMC enrollees (age 6 - 64) attributed[2] to a BH IPA.

#	Measure Name	Source/Developer	Numerator	Denominator
IV.	Increase[1] in Engagement in Community-Based Mental Health Care After a Mental Health Hospitalization	NYS	Number of inpatient discharges with a primary diagnosis of mental illness or intentional self-harm for MMC enrollees (age 6 - 64) attributed[2] to a BH IPA who had at least five follow-up community-based mental health care visits within 90 days after discharge.	Number of inpatient discharges with a primary diagnosis of mental illness or intentional self-harm during the discharge period[5] for MMC enrollees (age 6 - 64) attributed to a BH IPA.

[1] NYS will calculate the increase or decrease of the measures in the performance periods to determine the achievement.
[2] MMC enrollees attributed to a BH IPA include MMC enrollees who received at least one behavioral health service (defined in section B.II above) from any network provider of the BH IPA.
[3] The index visit is the earliest visit with an opioid dependence disorder diagnosis during the Intake Period. The patients must have a period of 60 days before the index visit when the member had no claims/encounters with a diagnosis of opioid dependence disorder.
[4] Intake period for Baseline Period is 4/1/2023 through 8/31/2023. Intake period for Performance Period 1 is 4/1/2024 to 8/31/2024. Intake period for Performance Period 2 is 10/1/2024 to 2/28/2025.
[5] Discharge period for Baseline Period is 1/1/2023 through 6/30/2023. Discharge period for Performance Period 1 is 1/1/2024 to 6/30/2024. Discharge period for Performance Period 2 is 7/1/2024 to 12/31/2024.

2. BH IPA Performance Measure Supplemental Specifications

I. Opioid Use Disorder (OUD) Medication Initiation

Percentage of MMC enrollees 18 years and older attributed to a BH IPA who initiated pharmacotherapy treatment within 30 days following an index visit with a diagnosis of opioid dependence.

Definitions

Intake period	Intake period for Baseline Period is 4/1/2023 through 8/31/2023. Intake period for Performance Period 1 is 4/1/2024 to 8/31/2024. Intake period for Performance Period 2 is 10/1/2024 to 2/28/2025.
Index visit	The index visit is the earliest visit with an opioid dependence disorder diagnosis during the Intake Period. The patients must have a period of 60 days before the index visit when the member had no claims/encounters with a diagnosis of opioid dependence disorder.

Denominator

MMC enrollees 18 years and older attributed to a BH IPA who during the intake period had an index visit with a diagnosis of opioid dependence. Eligible population also meet the following criteria:

Ages	18 years and older as of the end of the measurement period.
Continuous enrollment	Continuous enrollment in Medicaid 60 days prior to the index visit through 29 days (inclusive) after the index visit.
Exclusion	Individuals in hospice, individuals who died any time during the measurement period, or individuals with Medicare eligibility are excluded from the eligible population (e.g., denominator)
Event/diagnosis	An index visit with a diagnosis of opioid dependence. Any of the following meet criteria for an index visit: • An outpatient visit, intensive outpatient visit, or partial hospitalization with a diagnosis of opioid abuse or dependence. • An Emergency Department (ED) visit with a diagnosis of opioid abuse or dependence. • A detoxification visit with a diagnosis of opioid abuse or dependence. • An acute or nonacute inpatient discharge with a diagnosis of opioid abuse or dependence.

Numerator

Eligible population (defined in the denominator) who initiated pharmacotherapy treatment within 30 days following an index visit with a diagnosis of opioid dependence. Any of the following will identify initiation of pharmacotherapy treatment for opioid abuse or dependence:

- A Medication Assisted Therapy Dispensing Event.
- Dispensed a prescription for Opioid Abuse or Dependence.

II. 7-day Follow-Up After High-Intensity Care for Substance Use Disorder

Percentage of inpatient, residential treatment and detoxification visits or discharges for a diagnosis of Substance Use Disorder (SUD) among MMC enrollees 13 years and older attributed to a BH IPA who had follow-up care for a diagnosis of SUD within 7 days.

Definitions

Episode Date The date of service for any acute inpatient discharge, residential treatment discharge or detoxification visit with a principal diagnosis of substance use disorder.

For an acute inpatient discharge or residential treatment discharge, the Episode Date is the date of discharge. For a detoxification visit, the Episode Date is the date of service.

Denominator

Number of inpatient, residential treatment and detoxification visits or discharges for a diagnosis of SUD among MMC enrollees 13 years and older attributed to a BH IPA. Eligible population also meet the following criteria:

Ages 13 years and older as of the episode date.

Continuous enrollment Continuous enrollment in Medicaid from the episode date through 30 days after episode.

Exclusion Individuals in hospice, individuals who died any time during the measurement period, or individuals with Medicare eligibility are excluded from the eligible population (e.g., denominator).

Event/diagnosis An acute inpatient discharge, residential treatment or detoxification event for a principal diagnosis of substance use disorder during the first 5 months of the measurement period.

Any acute inpatient or residential treatment episodes followed by direct transfer to an acute inpatient or residential care setting within the 30-day follow-up period are excluded.

Only the first eligible episode per 31-day period is included if a member has more than one eligible episode in a 31-day period.

Numerator

Number of inpatient, residential treatment and detoxification visits or discharges for a diagnosis of SUD for eligible population (defined in the denominator) who had follow-up care for a diagnosis of SUD within 7 days. Any of the following meet criteria for a follow-up visit. Visits that occur on the date of discharge are not included.

- OASAS certified programs

- Other SUD services defined by HEDIS Follow-Up After High-Intensity Care for Substance Use Disorder (FUI) measure (identified using combination of procedure codes, revenue codes, place of service codes and specialty codes), please refer to HEDIS manual for more details.

III. 7-day Follow-Up After Hospitalization for Mental Illness

Percentage of inpatient discharges with a primary diagnosis of mental illness or intentional self-harm for MMC enrollees (age 6 - 64) attributed to a BH IPA who had a follow-up visit with a mental health provider within 7 days after discharge.

Denominator

Number of inpatient discharges with a primary diagnosis of mental illness or intentional self-harm during the first 5 months of the measurement period for MMC enrollees (age 6 - 64) attributed to a BH IPA. Eligible population also meet the following criteria:

Ages	6 to 64 as of the date of discharge.
Continuous enrollment	Continuous enrollment in Medicaid from the date of discharge through 30 days after discharge.
Exclusion	Individuals in hospice, individuals who died any time during the measurement period, or individuals with Medicare eligibility are excluded from the eligible population (e.g., denominator).
Event/diagnosis	An acute inpatient discharge with a primary diagnosis of mental illness or intentional self-harm on the discharge claim during the first 5 months of the measurement period. Any discharges followed by readmission or direct transfers to an inpatient setting within the 30-day follow-up period are excluded.

Numerator

Number of inpatient discharges with a primary diagnosis of mental illness or intentional self-harm for eligible population (defined in the denominator) who had a follow-up visit with a mental health provider within 7 days after discharge. Any of the following meet criteria for a follow-up visit. Visits that occur on the date of discharge are not included.

- OMH licensed outpatient services (identified using rate codes) except mobile crisis, crisis residence and Comprehensive Psychiatric Emergency Program (CPEP)
- Other mental health services defined by HEDIS Follow-Up After Hospitalization for Mental Illness (FUH) measure (identified using combination of procedure codes, revenue codes, place of service codes and specialty codes), please refer to HEDIS manual for more details.

IV. Engagement in Community-Based Mental Health Care After a Mental Health Hospitalization

Percentage of inpatient discharges with a primary diagnosis of mental illness or intentional self-harm for MMC enrollees (age 6 - 64) attributed to a BH IPA who had at least five follow-up community-based mental health care visits within 90 days after discharge.

Definitions

Discharge period Discharge period for Baseline Period is 1/1/2023 through 6/30/2023. Discharge period for Performance Period 1 is 1/1/2024 to 6/30/2024. Discharge period for Performance Period 2 is 7/1/2024 to 12/31/2024.

Denominator

Number of inpatient discharges with a primary diagnosis of mental illness or intentional self-harm during the discharge period for MMC enrollees (age 6 - 64) attributed to a BH IPA. Eligible population also meet the following criteria:

Ages 6 to 64 as of the date of discharge.

Continuous enrollment Continuous enrollment in Medicaid from the date of discharge through 90 days after discharge.

Exclusion Individuals in hospice, individuals who died, or individuals with Medicare eligibility any time during the measurement period or discharge period are excluded from the eligible population (e.g., denominator).

Event/diagnosis An acute inpatient discharge with a primary diagnosis of mental illness or intentional self-harm on the discharge claim during the discharge period.

Any discharges followed by direct transfer to acute/non-acute inpatient setting within the 90-day follow-up period are excluded.

Any discharges followed by readmission to **non-acute** inpatient setting within the 90-day follow-up period are excluded. Any discharges followed by readmissions with total length of stay of 42 days or more to **acute** inpatient setting within the 90-day follow-up period are excluded.

Numerator

Number of inpatient discharges with a primary diagnosis of mental illness or intentional self-harm for eligible population (defined in the denominator) who had at least five follow-up community-based mental health care visits within 90 days after discharge. Any of the following meet criteria for a follow-up visit.

- OMH licensed outpatient services (identified using rate codes) except mobile crisis, crisis residence and Comprehensive Psychiatric Emergency Program (CPEP). Assertive Community Treatment (ACT) and Personalized Recovery Oriented Services (PROS) services are billed monthly and should be counted as specified below[1]:
    - ACT
        - ACT Intensive Full Payment (rate code 4508) counts as 2 visits
        - ACT Intensive Partial Payment (rate code 4509) counts as 1 visit
    - PROS
        - PROS Common Rehab Services in Tiers 1-5 (rate codes 4520, 4521, 4522, 4523, 4524) count as 2 visits
        - PROS Pre-Admission (rate code 4510) counts as 2 visits (this service cannot be billed for more than 2 consecutive months)
        - PROS add-on services, specifically PROS Clinic Treatment (rate code 4525), PROS Intensive Rehab (rate code 4526), or PROS Ongoing Rehab and Support (rate code 4527) count as 1 visit.
- Other mental health services at a clinic or with an outpatient practitioner; or other mental health services defined by HEDIS Follow-Up After Hospitalization for Mental Illness (FUH) measure (identified using combination of procedure codes, revenue codes, place of service codes and specialty codes). Please refer to HEDIS manual for more details.

[1] With anticipated billing redesign in ACT and PROS, the State may update this guidance to reflect these changes if applicable.