DSRIP Regulatory and Integration Update

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Regulatory Waiver Authority

PHL § 2807(20)(e) and (21)(e) authorize the waiver of regulatory requirements for DSRIP projects and capital projects that are associated with DSRIP projects by:

- the Department of Health (DOH), the Office of Mental Health (OMH), the Office of Alcoholism and Substance Abuse Services (OASAS), and the Office for People With Developmental Disabilities (OPWDD)

A waiver may be issued:

- as necessary to allow applicants to avoid duplication of requirements and to allow the efficient implementation of the proposed projects;
- only if the waiver would not jeopardize patient safety; and
- only for the life of the project.

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Requests for Regulatory Waivers

- 624 requests were received for regulatory waivers
- Of those 44% approved, 2% denied, 15% no waiver needed
- Coordinated review process by DOH, OMH, OASAS and OPWDD
- Most common requests- Integrated services, Public Need and Financial Feasibility, Co-location/Shared Space

The Imperative to Facilitate the Integration of Care

- Individuals often have co-occurring physical and behavioral health needs
- New York's structure for providing health and behavioral health care services historically has been fragmented, impeding providers that desire to serve patients with multiple needs and resulting in higher costs
- Accordingly, New York State has recognized the critical need to pursue the integration of substance use disorder and mental health services as well as the integration of these services with physical health care services and to improve the overall coordination and accessibility of care

DSRIP Project 3.a.i Licensure Thresholds

Additional options for integration are also available to providers participating in DSRIP.

DSRIP Project 3.a.i Licensure Thresholds allow **up to 49% of visits** to be for non-licensed / non-certified services, without requiring an additional license or certification.

- For these licensure thresholds to apply, the provider must be identified as participating in a PPS's 3.a.i project and have the appropriate DSRIP regulatory waiver for one of the following:

A facility licensed by **DOH** requires a waiver for adding MH and/or SUD services

A facility licensed by **OMH** requires a waiver for adding PC and/or SUD services

A facility certified by **OASAS** requires a waiver for adding PC and/or MH services

Note: Providers that integrate services under the DSRIP Project 3.a.i Licensure Threshold will only be able to use this approach for the life of the DSRIP program

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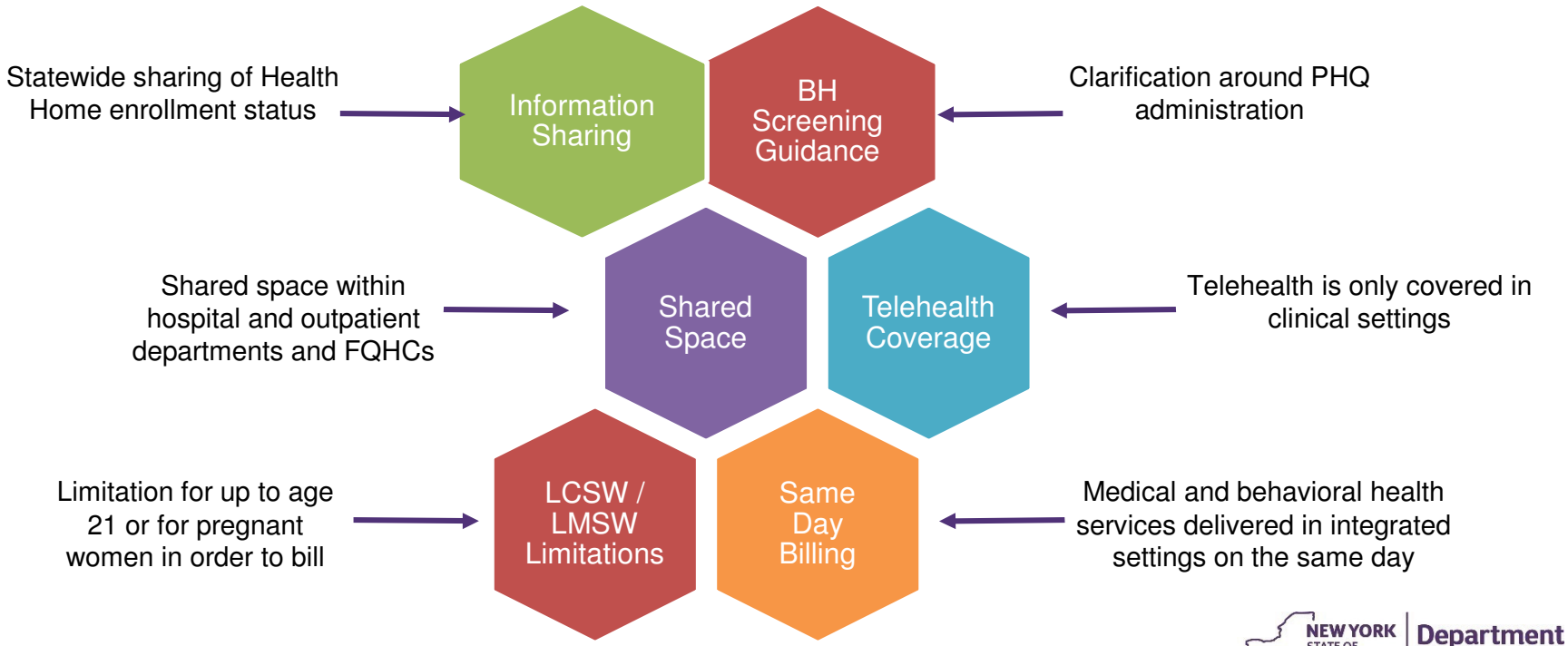
May 2015. New York State Department of Health. Guidance for DSRIP Performing Provider Systems Integrating Primary Care and Behavioral Health Services under Project 3.a.i.

Regulatory Waivers to Promote Behavioral Health Integration under DSRIP Project 3.a.i.

- Raised the threshold visits for integrated care to 49% at Article 28 (DOH), Article 31 (OMH) provider sites involved in PPS projects.
- Changed billing policy to pay for 2 facility visits in one day for both physical and behavioral health services for PPS providers under APG reimbursement methodology.
- Streamlined application process for sites to benefit from the above changes and to add services that must be certified or licensed.

Issues/Questions for Implementation

The following issues and questions emerged from PPS discussions with DOH, OMH, and OASAS.



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Integration Models

Single vs Separate & Distinct Providers

- Integrated Services Provider
  - A single provider billing 2 Evaluation & Management Codes on the same date of service
- Co-location and Shared Space
  - Two distinct/separate provider organizations (separate corporate structures)
- The specific model for each situation need to be known to respond with accuracy.

Integration Models and Approaches for a Single Provider

- Licensure Thresholds
- DSRIP Project 3.a.i Licensure Threshold
- Integrated Outpatient Services (IOS) Regulations
- Multiple Licenses by different state agencies

Totals

DSRIP 3.a.i.

- 5 OMH host sites total
  - 1 with SUD
  - 3 with primary care
  - 1 with both
- 4 OASAS host sites total
  - 1 with MH
  - 2 with primary care
  - 1 with both
- 5 DOH host site total
  - 4 with MH
  - 0 with SUD
  - 1 with both

Totals

Integrated Outpatient Services

- 14 OMH host sites total
  - 7 with SUD
  - 6 with primary care
  - 1 with both
- 8 OASAS host sites total
  - 6 with MH
  - 2 with primary care
  - 0 with both
- 0 DOH host sites total
  - 0 with MH
  - 0 with SUD
  - 0 with both

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Integration Models and Approaches for Different Providers

- Co-Location
- Shared Space

Co-Location

Co-location - Arrangement where two or more providers are located at the same physical address, but are not sharing any physical space.

Co-located providers:

- may share public space within a building that is accessible to patients of all providers. These spaces include entrances, exits, atria, elevators and staircases.
- may not share or commingle staff. Individuals may be employees of both providers, but their schedules must not overlap.
- CMS has indicated that FQHCs that share waiting rooms with other co-located providers may be approvable on a case by case basis.

Shared Space

Shared Space - Arrangement where two or more providers work together to deliver care by sharing physical space.

Challenges

- Restrictive CMS regulations on shared space and co-location
- Culture change
- BH workforce shortages
- Physical plant requirements for integrated clinic space.
- Reporting policies and procedures relating to Federal Block Grant funding under a single operating issue.
- Exchange of information that is legally permissible, and that which requires specific permission to satisfy Privacy and Confidentiality requirements.

Challenges

- Payment systems to support Integrated Care, including:
  - FQHCs Prospective Payment System where one service can be billed in the same day
  - What are the “integrated care” rates in a managed care environment?
  - Who can and should be credentialed and able to bill and be paid for providing those service(s)?

QUESTIONS??