NEW YORK STATE | Department of Health

Frequently Asked Questions (FAQs)

Approaches to Integrated Care

Integrated Care Approaches FAQs - January 2016

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Contents

Frequently Asked Questions (FAQs) – Approaches to Integrated Care

These Frequently Asked Questions (FAQs) issued by the New York State (NYS) Department of Health (DOH), the New York State Office of Mental Health (OMH) and the New York State Office of Alcoholism and Substance Abuse Services (OASAS) will provide guidance to providers that wish to integrate primary care (PC) and mental health (MH) and/or substance use disorder (SUD) services. Behavioral Health (BH) includes both MH and SUD services. The FAQs cover the following approaches:

- Licensure Thresholds
- Delivery System Reform Incentive Payment (DSRIP) Project 3.a.i Licensure Threshold
- Integrated Outpatient Services (IOS) Regulations
- Collaborative Care
- Multiple Licenses

New questions added to this FAQ and updated answers (released August 12, 2016) are updated in red. All questions included relate specifically to NYS Public Health Law (PHL) Article 28, NYS Mental Hygiene Law (MHL) Article 31, and NYS MHL Article 32. This does not reflect questions regarding private practices.

Integrated Care

1. Q: How does the Waiver Amendment relate to the Medicaid Redesign Team? Why is integration of PC and BH (MH and/or SUD) services important?

A. Health care providers have long recognized that many patients have multiple physical and BH care needs, yet services have traditionally been provided separately. The integration of PC, MH and/or SUD services can help improve the overall quality of care for individuals with multiple health conditions by treating the whole person in a more comprehensive manner.

2. Q. Within New York State, an 822 clinic has restrictions in terms of sharing patient information at the State level. Will State agencies look into the obstacles regarding improving communication between health organizations?

A. All involved agencies continue to explore strategies to assist providers in implementing "true" integration while maintaining compliance with federal law and regulations. However, federal confidentiality requirements contained in 42 CFR Part 2 continue to apply to SUD treatment records and information unless exception provided under the federal law/regulations are met.

Licensure Threshold

3. Q. What are Licensure Thresholds?

A. A licensed or certified outpatient provider may add PC, MH services under a single license or certification without any additional licenses or certifications, as long as the service to be added does not exceed the applicable Licensure Threshold.

Licensure Thresholds are not currently applicable for SUD services; OASAS certification is required if a clinic licensed by DOH or OMH wishes to provide any SUD services.

- A clinic site licensed by DOH pursuant to PHL Article 28 must also be licensed by OMH if it provides more than 10,000 annual MH visits, or if more than 30 percent of its annual visits are for MH services. The policy is the lowest of 30%/10,000 visits.

- A clinic site licensed by OMH pursuant to MHL Article 31 or certified pursuant to MHL Article 32 must also be licensed by DOH if more than 5 percent of its visits are for medical services or any visits are for dental services.

The provider that integrates services under the applicable Licensure Threshold must follow the programmatic standards of its licensing agency.

More information can be found here: http://www.health.ny.gov/press/releases/2008/2008-03-04_con_reform_ambulatory_care_services.htm.

4. Q. Under the current Licensure Threshold, can a primary care provider (PCP) offer SUD services?

A. Under the current Licensure Threshold regulations a PCP may not provide SUD services without being certified by OASAS pursuant to MHL Article 32.

Under DSRIP Project 3.a.i Licensure Threshold, OASAS will implement a Licensure Threshold for DSRIP providers participating in project 3.a.i so that PCP may provide up to 49% of its total annual visits for SUD services without MHL Article 32 certification.

5. Q. What is the application process to integrate services under the current Licensure Thresholds?

A. The provider does not need to submit an application to add services as long as the number of visits does not exceed the applicable Licensure Thresholds (non-DSRIP).

6. Q. Which State agency is responsible for oversight of the provider that integrates services under the Licensure Thresholds?

A. The State agency that licensed or certified the provider is responsible for regulatory oversight of the provider.

DSRIP Project 3.a.i Licensure Threshold

7. Q. What is the DSRIP Project 3.a.i Licensure Threshold?

A. A licensed or certified provider that is part of DSRIP Project 3.a.i may integrate PC, MH and/or SUD services under a single license or certification as long as the service to be added is not more than 49 percent of the provider's total annual visits ("DSRIP Project 3.a.i Licensure Threshold") and the patient initially presents to the provider for a service authorized by such provider's license or certification.

A licensed or certified provider is part of DSRIP Project 3.a.i if it is responsible for implementing one of the project's models as identified in the Performing Provider System's (PPS') implementation plan (i.e., Model 1 (Patient Centered Medical Home (PCMH)), Model 2 (BH), Model 3 (Improving Mood – Promoting Access to Collaborative Treatment (IMPACT))).

The provider that integrates services under the DSRIP Project 3.a.i Licensure Threshold must follow the programmatic standards of its licensing agency and the supplemental requirements for added service(s) as outlined in the DSRIP Licensure Threshold Guidance, which can be found here:

https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/regulatory_waivers/licensure_threshold_guidance.htm

8. **Q. What is the application process if a provider wishes to integrate services under the DSRIP Project 3.a.i Licensure Threshold?**

A. The provider must submit an application to and receive approval from the agency that licensed or certified the provider site. The provider does not need to have an integrated services license prior to submitting an application to participate in the DSRIP Project 3.a.i Licensure Threshold.

- A provider licensed by DOH pursuant to PHL Article 28 seeking to add BH services must submit a Certificate of Need (CON) application or a Limited Review Application (LRA) through NYSE-CON. A separate application is required for each site.
- A provider licensed by OMH pursuant to MHL Article 31 seeking to add PC or SUD services or certified by OASAS pursuant to MHL Article 32 seeking to add PC or MH services must submit the "DSRIP Project 3.a.i Licensure Threshold Application." The provider can include all the sites that wish to integrate services on a single application.

The application documents and instructions can be found here:
http://www.health.ny.gov/health_care/medicaid/redesign/dsrip/regulatory_waivers/draft_appl_instructions.htm

9. **Q. Can providers submit applications on a rolling basis as the need for higher thresholds arise?**

A. Before the 2008 standard visit thresholds are exceeded, there are two steps to be completed: 1) the submission of the waiver and 2) following approval of the waiver, the provider should complete the LRA or CON if they are an Article 28 and a DSRIP Project 3.a.i Licensure Threshold Application if they are an Article 31 or 32. Once the PPS has submitted the Regulatory Waiver Request for DSRIP Project 3.a.i service integration (on a PPS level), providers can submit site-specific applications at any time in order to provide services under this project. The August 1, 2016 deadline was for any PPS who would like to request any additional Regulatory Waivers not already submitted in the first two rounds, not site-specific DSRIP Project 3.a.i licensure threshold applications. If there are time-sensitive waiver needs in between waiver request rounds, these can be addressed on a case-by-case basis.

10. **Q. If the PPS Lead has already filed for a waiver under DSRIP Project 3.a.i, does the Lead need to submit the names and sites for any providers and sites that will be added?**

A. The PPS Lead will need to fill out provider/site specific information on the Regulatory Waiver and Project Tracking document (discussed in the August 3, 2016 Regulatory Waiver & Project Tracking Tool Webinar). In addition, any information for waivers requiring site specific information or approval on a case-by-case basis must be submitted. Both the completion of the Tracking Document and, any additional information as indicated in the PPS regulatory waiver response letter, are required prior to site approval of the waiver. For DSRIP Project 3.a.i Licensure Threshold, in addition to the PPS Lead requesting the regulatory waiver, providers need to submit either a CON/LRA or DSRIP Integrated Services Application, as outlined in the Integrated Services Overview webinar for site specific approval.

The Regulatory Waiver and Project Tracking webinar is only posted to the DSRIP Digital Library, available only to individuals with MAPP access.

The Integrated Services Overview webinar may be found at:
http://www.health.ny.gov/health_care/medicaid/redesign/dsrip/webinars_presentations.htm

11. Q. How do providers know if the PPS requested a waiver?

A. Regulatory Waiver guidance, including requests and responses, are on the DOH website: https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/reg_flex_guide_res_prog_stat_waiver_resp_approvals.htm.

Providers should be in discussions with their PPS in order to determine which projects they will be participating in and site specific requests for waivers, which must have PPS support.

12. Q. What are the requirements for the PPS Lead's letter of support in the licensure threshold application process?

A. The PPS Lead's letter of support must include the specific site and services to be added, in addition to indicating this is part of the PPS' DSRIP Project 3.a.i.

13. Q. How long does the review process take before regulatory approval is issued and the applicant can begin integrating services?

A. Overall application process takes 4-6 weeks. Timeline delays may occur in the event of incomplete applications.

14. Q. If a licensed or certified provider wishes to integrate services and is a PPS provider partner as identified on the PPS Performance Network List but is not involved in Project 3.a.i, can the provider use this approach?

A. No. This approach exists specifically to advance the integration of PC and BH services as part of DSRIP Project 3.a.i. The PPS Lead is responsible for identifying which provider partners in its network (including their sites) will be pursuing which DSRIP Project 3.a.i model(s), as identified in its implementation plan (i.e., Model 1 (PCMH), Model 2 (BH) or Model 3 (IMPACT)). These providers may submit an application for the participating sites as described in FAQ #8.

15. Q. If an agency has multiple sites, across multiple counties, are they required to consult and receive approval from each county's Local Government Unit (LGU)? Is there a set of questions or specific response that the State will be looking for as it relates to LGU consultation?

A. The applicant will need to reach out to the respective government unit for each site at which they want to integrate services. There are no set of questions or specific responses that the State will be looking for as it relates to LGU consultation.

16. Q. Is a PHL Article 28 licensed provider licensed in a category other than PC, able to add BH services under the DSRIP Project 3.a.i Licensure Threshold?

A. No. This approach exists specifically to advance the integration of PC and BH services as part of DSRIP Project 3.a.i. Only a provider that is part of Project 3.a.i (as explained in FAQ #14), and is licensed by DOH pursuant to PHL Article 28 in PC (i.e., operating certificate should list “medical services – primary care”) may apply.

17. Q. If a licensed or certified provider that is part of DSRIP Project 3.a.i receives approval to integrate services under the DSRIP Project 3.a.i Licensure Threshold, will the added service be reflected on the provider’s operating certificate?

A. If a provider licensed by DOH is approved to add MH and/or SUD services, the added service(s) will appear on the provider’s operating certificate as follows: DSRIP IOS (MH) and/or DSRIP IOS

(SUD). If a provider licensed by OMH or certified by OASAS is approved to add PC and/or the other BH services, the provider will receive an approval letter from its licensing or certifying agency.

18. Q. Does a PPS provider partner that wishes to integrate services under the DSRIP Project 3.a.i Licensure Threshold need to be affiliated with a health home?

A. A licensed or certified outpatient provider that wishes to integrate services under the DSRIP Project 3.a.i Licensure Threshold does not need to be affiliated with a health home in order to apply, as it would for participation under the IOS regulations.

However, PPSs, as well as their network partners participating in Project 3.a.i, should keep in mind that a requirement of DSRIP is to have Health Homes participating in the network. Health Homes include former targeted case management (TCM) providers who specialized in BH populations. Health Homes should be a resource for care management in any project involving BH services.

19. Q. If a licensed or certified provider is part of DSRIP Project 3.a.i and wishes to integrate services but does not anticipate exceeding the applicable non-DSRIP "Licensure Threshold," does the provider still need to submit an application?

A. No. However, a provider may not provide services or bill Medicaid for any service rendered above the applicable Licensure Threshold unless the appropriate approval is in place. Therefore, when a provider approaches the Licensure Threshold, the provider should consider seeking approval from the relevant State agency to add services above the Licensure Thresholds up to the DSRIP Project 3.a.i Licensure Threshold, if applicable. As always, the provider also would have the option of integrating services by either seeking a second license for a particular site or integrating services under the IOS regulations, if applicable (see 10 NYCRR Part 404, 14 NYCRR Part 598 and 14 NYCRR Part 825).

20. Q. If a PPS provider is approved to integrate services under the DSRIP Project 3.a.i Licensure Threshold, does the provider need to meet all the requirements of the IOS regulations as well?

A. In addition to following the programmatic standards of its licensing agency, the provider needs to meet the prescribed requirements of the IOS regulations as outlined in the DSRIP Licensure Threshold Guidance, which can be found here: https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/regulatory_waivers/licensure_threshold_guidance.htm

21. Q. How is a provider supposed to define a visit for purposes of calculating the DSRIP Licensure Threshold?

A. The DSRIP Licensure Threshold Calculation Methodology will be available soon. Please continue to watch the webpage, which can be found here: https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/regulatory_waivers/draft_appl_instructions.htm

22. Q. If a PC site stays below the original BH threshold, do they need to submit a waiver?

A. A PC site can provide up to 10,000 MH visits or up to 30% of its annual visits for MH services under the 2008 Licensure Threshold without a waiver or application.

23. Q. What happens when a provider approaches the 49 percent threshold for the added service?

A. The provider has the option of integrating services by either seeking a second license for a particular site or integrating services under the IOS regulations (see 10 NYCRR Part 404, 14 NYCRR Part 598 and 14 NYCRR Part 825), if applicable. A provider that elects to integrate services under the IOS regulations will need to comply with all applicable provisions under the regulations.

24. Q. In order to go above the licensure threshold, is it necessary to apply to be part of DSRIP Project 3.a.i in the PPS?

A. In order to add PC services above the 5% 2008 Licensure Threshold, MHL Article 31 and 32 providers can: 1) apply for DSRIP Project 3.a.i Licensure Threshold, 2) apply for IOS if the applicant already has a PHL Article 28 license at any of their sites, or 3) apply for multiple licenses. Providers do need to be participating in their PPS' DSRIP Project 3.a.i in order to apply for the DSRIP Project 3.a.i Licensure Threshold levels.

25. Q. Which State agency is responsible for oversight of a provider that integrates services under the DSRIP Project 3.a.i Licensure Threshold?

A. The State agency that licensed or certified the provider is responsible for regulatory oversight of the provider.

26. Q. What happens to a provider that integrates services under the DSRIP Project 3.a.i Licensure Threshold at the end of the DSRIP program?

A. This approach is limited to the life of the DSRIP program. As eligible providers take advantage of this approach, the State agencies will be able to assess the effectiveness of this approach and decide whether to pursue its continuation, with any appropriate adjustments.

27. Q. How is 42 CFR Part 2 applicable to providers in DSRIP projects that seek to offer SUD treatment services?

A. The federal confidentiality law, 42 CFR Part 2, controls the privacy of, access to and maintenance of patient records of federally funded alcohol and drug abuse providers. This would include any provider under DSRIP that seeks to add SUD treatment services. A provider who provides SUD treatment under any of the integrated services models, including DSRIP thresholds, must comply with these rules. Accordingly, a provider licensed by DOH pursuant to PHL Article 28 or by OMH pursuant to MHL Article 31 that delivers SUD services must comply with 42 CFR Part 2.

28. Q. What is the threshold for MH visits in an MHL Article 31 and Article 32 (non-DSRIP Project 3.a.i)?

A. OMH and OASAS currently allow their respectively-licensed clinics to treat individuals with co-occurring MH and SUD. There is no specific threshold that dictates volume under these circumstances; however individuals are required to have a primary SUD to be admitted to an OASAS clinic. If the provision of more extensive MH services is desired, DSRIP Project 3.a.i. approval would be recommended.

29. Q. If a facility has an OMH, OASAS and DOH license, are they required to submit a CON or LRA to provide integrated licensure services in a PHL Article 28 clinic outside of DSRIP?

A. A site licensed by all three State agencies may provide all services with no threshold limitations. Outpatient providers licensed or certified by at least two participating State agencies who wish to

integrate services at another site can apply for IOS. Outpatient providers licensed under PHL Article 28 must complete an LRA (if a provider wishes to add MH or SUD services at an existing clinic and the project costs do not exceed $6,000,000) or a CON (if the project costs exceed $6,000,000 or the provider wishes to certify a new extension clinic).

DSRIP Project 3.a.i Licensure Threshold Methodology

30. Q. In determining a provider's status related to the thresholds, what is the unit of measurement (e.g. billing codes or Ambulatory Patient Groups (APGs))?

A. The Department is working on a webinar to explain the licensure threshold calculation methodology, which is tentatively scheduled for Fall 2016. The calculation methodology will be based on encounters represented by the evaluation and management (E&M) code and the primary and secondary diagnosis codes for the visit, which will determine the APG group.

31. Q. What happens to licensure thresholds when DSRIP expires?

A. 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. As the end of DSRIP approaches, it is possible there will be alternative strategies, but this is unknown at this time.

32. Q. Are the percentage thresholds for integrated services based on Medicaid visits only for non-DSRIP integrated services?

A. The percentage thresholds for integrated services are computed against the total Medicaid visits provided, whether DSRIP or non-DSRIP. The Department is working on a webinar to explain the licensure threshold calculation methodology, which is tentatively scheduled for Fall 2016.

Integrated Outpatient Services Regulations

33. Q. What is the definition of Primary Care?

A. DOH defines “primary care services” as “services provided by a physician, nurse practitioner, or midwife acting within his or her lawful scope of practice under Title VIII of the Education Law and who is practicing primary care.” The OMH and OASAS regulations include the same language.

More information can be found here:
https://www.health.ny.gov/facilities/cons/limited_review_application/lra_instructions_outpatient.htm

34. Q. How does a provider add services under the IOS regulations?

A. An outpatient provider that is licensed or certified by more than one agency may add PC, MH and/or SUD services at one of its sites without having to obtain an additional license or certification, as long as it is licensed or certified to provide such services at another location.

There are three models:

- Primary Care Host Model
- Mental Health Behavioral Care Host Model
- Substance Use Disorder Behavioral Care Host Model

The "host site" is the single outpatient site at which a provider who is licensed or certified by DOH, OMH or OASAS is approved to provide integrated services as prescribed under the regulations.

The provider that integrates services under the integrated outpatient services regulations must follow the programmatic standards of the licensing agency that licensed the "host site" and follow supplemental requirements for added service(s) as outlined in the regulations.

- DOH licensed providers (10 NYCRR Part 404);
- OMH licensed providers (14 NYCRR Part 598); and
- OASAS certified providers (14 NYCRR Part 825).

Guidance regarding the IOS regulations is available at:
https://www.health.ny.gov/facilities/cons/limited_review_application/lra_instructions_outpatient.htm

35. Q. Are the IOS regulations limited to DSRIP providers?

A. No. The regulations are applicable to any eligible licensed or certified provider. However, a provider in a PPS network that is part of Project 3.a.i may opt to proceed under the IOS regulations if otherwise eligible and may wish to do so, for example, if it wishes to offer an additional type of services above the 49 percent DSRIP Project 3.a.i Licensure Threshold.

36. Q. Would a PC site licensed under PHL Article 28 be able to prescribe Suboxone if their provider is certified to do this under its PHL Article 28 license and not get certified by OASAS? The provider is prescribing as part of their PC service to their patient.

A. Requirements for prescribing Suboxone are subject to federal limitations pursuant to the controlled substances act and related regulations. OASAS is not opposed, provided the entity is not violating MHL §32.05 (entity cannot hold itself out as a SUD programs without OASAS certification). A physician may prescribe Suboxone under their scope of practice.

37. Q. Is the Health Care Coordinator role (as previously required by OASAS) still applicable under the integrated license?

A. Yes, for those programs that operate as an OASAS host site.

38. Q. If a patient sees their PCP and the diagnosis, among others, is depression, does that count as a MH visit?

A. Yes. The diagnosis of depression will count as a MH visit when seeing a PCP.

39. Q. Can an agency that is an OMH host site that has added OASAS services (with integrated licensing) co- treat with another OASAS agency?

A. Yes, an OMH Host IOS provider could refer a patient to a separate SUD provider to the extent that the host site is unable to provide services or a patient desires to use another SUD provider. Provider would continue to bill for the MH services delivered using the integrated rate code.

Approval to provide IOS is site specific; however providers can have multiple sites approved. There is no limit on the number of sites for which a provider can seek approval.

40. Q. Is a specialty care provider, e.g., a provider licensed by DOH pursuant to PHL Article 28 in a category other than PC, able to add MH and/or SUD services under the IOS regulations?

A. No. This approach exists specifically to advance the integration of PC, MH and SUD services and only a provider licensed by DOH pursuant to PHL Article 28 in PC (i.e., operating certificate that lists "medical services – primary care") may apply.

41. Q. The IOS regulations require the applicant to be a member of a health home designated by the Commissioner of Health. What information is required?

A. The applicant must indicate the Health Home Lead for which the applicant is a network partner as identified on the Network Health Home Partner List: (https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/contact_information/county_list.htm). If an applicant is not on the list, the applicant may provide other documentation of its affiliation with a health home (e.g., copy of contract, memorandum of understanding (MOU), etc. between applicant and the Health Home Lead).

42. Q. What is the application process under the IOS regulations?

A. The provider must submit an application to and obtain approval from the State agency that licensed the "host site."

A provider licensed by DOH pursuant to PHL Article 28 seeking to add MH and/or SUD services must submit a CON application or LRA through NYSE-CON. A separate application is required for each site**.**

- A provider licensed pursuant to MHL Article 31 seeking to add PC or SUD services or a provider certified pursuant to MHL Article 32 seeking to add PC or MH services must submit the "Integrated Services Application" available on the OMH and OASAS websites. A separate application is required for each site.

The application instructions and documents can be found here:

- DOH Application Instructions (Primary Care Host Model): https://www.health.ny.gov/facilities/cons/limited_review_application/lra_instructions_outpatient.htm
- OMH Application Instructions (Mental Health Behavioral Care Host Model): https://www.omh.ny.gov/omhweb/clinic_restructuring/integrated-services.html
- OASAS Application Instructions (Substance Use Disorder Behavioral Care Host Model): https://www.oasas.ny.gov/legal/CertApp/capphome.cfm

43. Q. When will the integrated services provider application approvals be released?

A. The process is currently up and running and applications are being accepted and reviewed on a rolling basis. Providers should contact their appropriate agencies for additional clarification and follow-up.

44. Q. Which State agency is responsible for regulatory oversight of the licensed or certified provider that integrates services under the IOS regulations?

A. The State agency responsible for regulatory oversight of the provider at a host site is the agency that initially licensed or certified the host site:

- Primary Care Host Model – DOH

- Mental Health Behavioral Care Host Model – OMH
- Substance Use Disorder Behavioral Care Host Model – OASAS

45. Q. Under the Mental Health Behavioral Care Host Model, is the host provider limited in the range of PC services that may be provided by the APG rate codes (i.e., health assessments and health monitoring)?

A. No. Any provider licensed by OMH pursuant to MHL Article 31 may offer health physicals and health monitoring as optional services, which do not count towards the 5% threshold. For more information about services that can be billed under the Mental Health Behavioral Care Host Model, please see the Integrated Outpatient Services – Implementation Guidance, which can be found here: https://www.health.ny.gov/facilities/cons/limited_review_application/lra_instructions_outpatient.htm

46. Q. How is 42 CFR Part 2 applicable to PC host and MH behavioral care host providers that offer SUD treatment services?

A. The federal confidentiality law, 42 CFR Part 2, controls the privacy of, access to and maintenance of patient records of federally funded alcohol and drug abuse providers. This would include PC host and MH behavioral care host providers of SUD treatment services.

A provider who provides SUD treatment under any of the integrated services models, including the IOS regulations, must comply with these rules. Accordingly, a PHL Article 28 or MHL Article 31 licensed provider that adds SUD services must comply with 42 CFR Part 2.

47. Q. Can a provider certified by OASAS pursuant to MHL Article 32 be approved to add PC services pursuant to the integrated outpatient regulations provide PC services to other Opioid Treatment Programs (OTP a/k/a MMTP) within the same organization?

A. Under the SUD behavioral care host model, the OASAS certified provider is only allowed to provide PC services at the approved host site and may not provide PC services at an OTP program operated by the same provider at another site without approval.
A separate application must be submitted for each OASAS certified site so that it may be separately considered for approval as a host site before it is able to add PC services.

48. Q. If a Diagnostic and Treatment Center receives approval to operate an Article 31 MH Clinic, can the operation of the MH services be conducted under the administration, management and support (clerical and others) staff of the Diagnostic & Treatment Center (D&TC)?

A. Yes, but only if the D&TC is correspondingly approved for “Certified Mental Health O/P” on its Article 28 operating certificate or is approved for “integration” under the IOS regulation. Otherwise, what is described would still require “separation” under existing constructs.

49. Q. Is methadone maintenance one of the OASAS services that can be integrated into a PC host site?

A. Providers interested in integrating methadone maintenance services into their program should reach out to the appropriate OASAS Field Office.

50. Q. Since nurse practitioners are recognized as independent practitioners in New York State, can they be licensed to prescribe buprenorphine?

A. No. Under the federal Drug Addiction Treatment Act (DATA) of 2000, only qualifying physicians who receive a waiver from the special registration requirements in the Controlled Substances Act are able to practice medication-assisted opioid addiction therapy with Schedule III, IV, or V narcotic medications specifically approved by the Food and Drug Administration (FDA).

The term "qualifying physician" is specifically defined in DATA 2000 as a provider meeting all of the following conditions: a physician who is licensed under State law, has a DEA registration number to dispense controlled substances, has the capacity to refer patients for counseling and ancillary services, will treat no more than 30 such patients at any one time for the first year, then no more than 100 patients at any one time thereafter provided the physician has received approval to increase capacity from the Substance Abuse and Mental Health Services Administration Center for Substance Abuse Treatment, and is qualified by certification, training, and/or experience to treat opioid addiction.

51. Q. How often is utilization review (UR) of services needed as required under 14 NYCRR 598.11(a)(2)(iii)(e) and 14 NYCRR 825.(a)(2)(iii)(e) of the IOS regulations?

A. The IOS regulations State that utilization reviews must be conducted for all active cases within the twelfth month after admission and every 90 days thereafter.

This is an increase from the utilization review requirements under OMH's Clinic Treatment Programs regulation (14 NYCRR Section 599.6(l)(2)), which allows for a review of the need for continued treatment in a clinic treatment program within seven months after admission and every six months thereafter. For MHL Article 31 licensed providers operating under the MH behavioral care host model, OMH will consider a regulatory waiver request pursuant to 14 NYCRR Part 501 to allow flexibility with respect to the frequency of the performance of utilization reviews. OMH is willing to consider a six-month review, consistent with 14 NYCRR Part 599, as the standard in certain cases, if the clinic provider adheres to the requirements of such Part with respect to utilization review, as well as all other pertinent regulatory provisions found in 14 NYCRR Parts 598 and 599.

For MHL Article 32 licensed providers operating under the SUD behavioral care host model, the MHL Article 32 certified provider only needs to follow the utilization review requirements under 14 NYCRR Part 822. However, the provider must submit a request pursuant to Mental Hygiene Law using the OASAS PAS-10 form to waive 14 NYCRR§ 825(a)(2)(iii)(e). The PAS-10 form can be found here: https://oasas.ny.gov/mis/forms/pas/index.cfm

Under the PC host model, utilization review must be conducted for all active cases within the twelfth month after admission and every 90 days thereafter.

52. Q. Do DOH/OMH/OASAS hosted program requirements change under the IOS regulations?

A. Absent other regulations, the host rules continue to apply.

53. Q. How does the new deeming law in effect in outpatient MH and SUD settings interact with the survey process for integrated services providers?

A. Via the new deeming law, with respect to OMH services, The Joint Commission (TJC) will add a surveyor with knowledge and experience in BH to the hospital survey team to conduct the survey of the outpatient program. OASAS is likewise working on a plan to allow deeming in hospital-based certified outpatient clinics. Once the joint- agency "Integrated Services Surveillance Tool" is finalized, it will be shared with the TJC to be incorporated within their outpatient surveillance functions.

54. Q. What will the fiscal viability review for integrated services clinics involve?

A. Fiscal viability reviews will be conducted for MH and SUD behavioral care host sites. The review will include the host site's most recent financial Statements and an assessment of whether assets are sufficient relative to liabilities. The outcome of the review will be a determination as to whether the provider's current fiscal health precludes the clinic from sustaining the provision of IOS pursuant to the IOS regulations.

Collaborative Care

55. Q. What is Collaborative Care?

A. Collaborative Care is an evidence-based model of BH integration for detecting and treating common MH conditions such as depression and anxiety in PC settings. Collaborative Care focuses on defined patient populations tracked in a registry, measurement-based treatment to target. Trained PCPs and embedded BH professionals provide evidence-based medication and/or psychosocial treatments, supported by regular psychiatric case consultation and treatment adjustment for patients who are not improving as expected.

56. Q. What is the New York State Medicaid Collaborative Care program?

A. The New York State Medicaid Collaborative Care Program was set up to sustain the work of practices that had implemented Collaborative Care as a part of the DOH Hospital Medical Home Demonstration project which ended in 2014. The Medicaid program provides a monthly case rate payment per patient to practices that are enrolled in this program, as well as ongoing technical assistance and training to the sites.

57. Q. Who are the participants in the Medicaid Collaborative Care Program?

A. Participants in the New York State Medicaid Collaborative Care Program are primarily those that had participated in the Medical Home Demonstration Project and are PHL Article 28 academic medical center- affiliated PC practices. The program also includes some federally qualified health centers (FQHCs).

58. Q. What is the application process for participating in the Collaborative Care initiative?

A. Currently, the New York State Medicaid Collaborative Care Program is not accepting new practices.

59. Q. Who is responsible for oversight under the Collaborative Care initiative?

A. OMH oversees sites participating in the New York State Medicaid Collaborative Care Program. They are required to report data to OMH and meet certain quality outcome standards.

60. Q. What is the difference between Collaborative Care and the IMPACT model?

A. IMPACT is a brand name for the Collaborative Care model. It was called IMPACT in the initial study done on the model which was limited to depression in older adults aged 55 and over, but has since been shown to be effective in treating other conditions, such as anxiety, and in populations other than the Medicare population. OMH uses the broader term "Collaborative Care" to describe the

model, which is not limited to a particular study, but it is still commonly known as IMPACT, as reflected in the DSRIP project.

61. Q. How can a provider implement the IMPACT model as part of DSRIP Project 3.a.i?

A. A PPS must have initially selected the IMPACT model as part of its 3.a.i project selection to obtain the project achievement value. For providers, there are many resources available to sites implementing Collaborative Care as a part of DSRIP. DSRIP funding can be used to support education and training from consultants and other technical assistance providers in order to build the team and implement the model. It has been shown to be cost effective by saving money from emergency room usage and hospital readmissions and admissions, and also by improving efficiencies within the practice. OMH encourages sites to partner with other sites in the PPS that are implementing Collaborative Care to learn from their experiences. A PPS and/or its network providers which are not implementing the IMPACT model may want to consider it as part of a future strategy in the context of Value Based Payment, given its evidence of improving outcomes and overall impact on medical utilization.

The University of Washington AIMS Center is an excellent source for information on the principles of Collaborative Care and provides a guide to implementation. Information is available at: http://aims.uw.edu/collaborative-care

62. Q. Are there plans to grow/expand the Collaborative Care program?

A. At this time, the New York State Medicaid Collaborative Care Program is not accepting new practices. The goal of the program is to gain support for the model in New York State and demonstrate the efficacy of this funding mechanism. A robust evaluation of this program will serve to inform the next iteration of Collaborative Care financing in NYS, as payers transition to Value Based Payment arrangements in the next few years. In addition to the Medicaid Collaborative Care program, efforts are ongoing to enlist commercial payer support of BH integration and Collaborative Care as integral parts of the Advanced Primary Care (APC) standards that practices will begin to implement in 2016. Practice transformation funding and support are available for practices carrying out APC.

63. Q. If a Psychiatrist wants to see a particular patient due to either non-response or diagnostic question, can that evaluation be billed through the Collaborative Care Model?

A. In the Collaborative Care model, the Psychiatrist does not routinely see patients face to face. In the event that they do, this is separate from Collaborative Care and would be billed the same as any encounter with the Psychiatrist would normally.

64. Q. What are the criteria for admission to the depression monthly case rate model and what are the outcome measures?

A. Any site can implement the Collaborative Care model, but only sites that are part of the New York State Medicaid Collaborative Care program can receive the monthly case rate reimbursement. These sites that are part of this program have been actively providing Collaborative Care for depression in their practice for several years. Participating sites report 11 measures to the NYS OMH on a quarterly basis.

Multiple Licenses

65. Q. How can a provider integrate services using multiple licenses?

A. A provider may opt to pursue the integration of PC, MH and/or SUD services by obtaining a license or certificate from each licensing agency (DOH, OMH or OASAS), as appropriate. This is an option, for example, if the provider wishes to exceed the Licensure Thresholds but is not eligible under the integrated outpatient services regulations or does not qualify to use the DSRIP Project 3.a.i Licensure Threshold approach, or wishes to exceed the 49 percent DSRIP Project 3.a.i Licensure Threshold. If two or more licenses/certifications are obtained, the provider must follow the programmatic standards of each licensing agency, as appropriate.

- DOH regulations, including 10 NYCRR Parts 401 and 751, can be found here: https://www.health.ny.gov/regulations/
- OMH regulations can be found here: https://www.omh.ny.gov/omhweb/clinic_restructuring/part599/
- OASAS regulations can be found here: https://www.oasas.ny.gov/regs/index.cfm

66. Q. What is the application process for a provider that wishes to integrate services using multiple licenses?

A. The provider must submit an application to and obtain approval from each licensing agency, as appropriate.

- DOH: CON or LRA. More information can be found here: https://www.health.ny.gov/facilities/cons.
- OMH: Prior Approval Review (PAR) or EZ PAR Application. More information can be found here: http://www.omh.ny.gov/omhweb/par/.
- OASAS: Certification Application. More information can be found here: http://oasas.ny.gov/legal/CertApp/capphome.cfm.

67. Q. When a provider has multiple licenses, which State agency is responsible for oversight?

A. Each State agency that licenses or certifies the provider is responsible for oversight of its agency's regulatory standards.

68. Q. If the thresholds are not an issue and a clinic is dually licensed as a PHL Article 28 and MHL Article 31, is there any other benefit to the IOS license for this clinic?

A. The benefit to IOS is that although a site may have multiple licenses, they are subject to the oversight of a single State agency. Please note providers must already be licensed or certified by more than one agency in order to participate in IOS.

Telehealth

69. Q. Do the IOS regulations cover services provided through telemedicine?

A. A provider licensed by OMH pursuant to MHL Article 31 under the MH behavioral care host model has the ability to utilize telepsychiatry for assessment and treatment services under existing OMH regulations.

OMH has issued regulations, effective February 11, 2015, establishing the basic standards and parameters for use of "telepsychiatry" in OMH- licensed clinic programs (14 NYCRR § 599.17). This regulation allows telepsychiatry to be utilized for assessment and treatment services provided by physicians or psychiatric nurse practitioners, from a site distant from the location of a recipient, where both the patient and the physician or nurse practitioner are physically located at clinic sites licensed by OMH (i.e., MHL Article 31 licensed clinic to MHL Article 31 licensed clinic).

"Telepsychiatry" is defined as the use of two-way real time-interactive audio and video equipment to provide and support clinical psychiatric care at a distance. Such services do not include a telephone conversation, electronic mail message or facsimile transmission between a clinic and a recipient, or a consultation between two professional or clinical staff.

OASAS is developing guidelines and protocols to support the use of telemedicine in OASAS certified programs, including SUD behavioral care host models. More information will be available in the future.

70. Q. Can a provider licensed by OMH pursuant to MHL Article 31 provide telepsychiatry services in conjunction with a provider licensed by DOH pursuant to PHL Article 28 that adds MH services under the PC host model or to a clinic certified by OASAS pursuant to MHL Article 32 that adds MH services under the SUD behavioral care host model?

A. OMH is continually exploring options to expand the use of telepsychiatry. However, the agency seeks to do so in a manner that utilizes the technology to supplement, not supplant, the need for psychiatric services in areas where there is not only need but a shortage of psychiatry personnel. In short, when contemplating whether telepsychiatry can be used in an "integrated" setting, the answer is dependent upon exactly how the technology is being proposed to be used in such a setting. What OMH is most concerned with is that, since telepsychiatry can be cost-effective, providers may choose to employ this technology as a cost-saving measure before the BH field knows if it is equivalent to in-person psychiatry in terms of its effectiveness. The factors for consideration by OMH would, therefore, include intent of use consistent with the delineated program standards, the need in the setting, and the status of psychiatry recruitment.

71. Q. Is there a billing mechanism for tele-services provided by a clinic licensed by OMH?

A. Once a provider licensed by OMH pursuant to MHL Article 31 has requested and received approval from OMH to provide telepsychiatry, pursuant to 14 NYCRR § 599.17, claims may be submitted for Medicaid fee-for-service and Medicaid managed care reimbursement if the clinic meets the requirements outlined in the "Telepsychiatry Standards Guidance" found here: https://www.omh.ny.gov/omhweb/clinic_restructuring/telepsychiatry.html

Medicaid Managed Care plans are currently required to reimburse clinics at the fee-for-service rates. This requirement will continue through at least the first two years of implementation of Health and Recovery Plans (HARPs) and the "carve-in" of all BH services into mainstream Medicaid Managed Care plans.

The services eligible for Medicaid and Medicaid managed care reimbursement when provided using telepsychiatry are: Initial Assessment, Psychiatric Assessment, Psychiatric Consultation, Crisis Intervention, Psychotropic Medication Treatment, Psychotherapy (Individual, Family, Group, and Family Group), Developmental Testing, Psychological Testing and Complex Care Management. Only physicians, psychiatrists and psychiatric nurse practitioners may deliver Medicaid fee- for-service and Medicaid managed care reimbursable telepsychiatric services.

Federal terms relevant for purposes of telepsychiatry reimbursement are "spoke" and "hub." The term "spoke" refers to the physical location of the patient during a telepsychiatric service. The term "hub"

means the physical location of the practitioner during a telepsychiatry service. To constitute a reimbursable service, the patient must be physically present at the clinic in which he/she is already enrolled or is presenting for assessment (i.e., the "spoke").

Medicaid payment policy for telehealth services can be found in the March 2015 Medicaid Update. The Department is in the process of drafting regulations to implement the recently enacted telehealth parity law.

OMH has issued regulations on telepsychiatry. Guidance is available here:
http://www.omh.ny.gov/omhweb/clinic_restructuring/telepsychiatry.html

March 2015 Medicaid Update:
http://www.health.ny.gov/health_care/medicaid/program/update/2015/2015-03.htm

72. Q. Do providers licensed by DOH pursuant to PHL Article 28 need approval from DOH to use telehealth modalities?

A. No. A PHL Article 28 licensed provider does not need to apply for permission from DOH to utilize telehealth. Telehealth modalities are viewed as another tool that providers can use to provide services under the existing category on their operating certificate. The New York State Medicaid Program provides coverage for services delivered via telehealth in some settings and by some provider types as described in FAQ #73 and FAQ #74. To obtain Medicaid reimbursement for services delivered via telehealth, a PHL Article 28 provider must comply with Medicaid policy and billing guidance.

73. Q. Is telehealth covered by New York State commercial insurers and the Medicaid Program?

A. Yes, in 2015, telehealth parity legislation was passed that requires commercial insurers and the Medicaid program to provide reimbursement for services delivered via telehealth to the same extent that services would be covered if provided in person. The legislation, which amended Public Health Law, Social Services Law, and Insurance Law, went into effect on January 1, 2016.

As defined in PHL Article 29-g, telehealth is the use of electronic information and communication technologies to deliver health care to patients at a distance, which includes the assessment, diagnosis, consultation, treatment, education, care management and/or self- management of a patient. Telehealth is limited to telemedicine (which includes telepsychiatry), store-and-forward, and remote patient monitoring.

Telemedicine allows a telehealth provider at a "distant site" to use synchronous, two-way electronic audio visual communications to deliver clinical health care services to a patient at an "originating site."

Store and forward technology is the asynchronous, secure electronic transmission of a patient's health information in the form of patient-specific digital images and/or pre-recorded videos from a telehealth provider at an originating site to a telehealth provider at a distant site.

Remote patient monitoring uses synchronous or asynchronous electronic information and communication technologies to collect personal health information and medical data from a patient at an "originating site"; this information is then transmitted to a provider at a "distant site" for use in treatment and management of unstable/uncontrolled medical conditions that require frequent monitoring. Such conditions shall include, but are not limited to, congestive heart failure, diabetes, chronic obstructive pulmonary disease, wound care, polypharmacy, mental or behavioral problems, and technology-dependent care such as continuous oxygen, ventilator care, total parenteral nutrition or enteral feeding. Remote patient monitoring must be ordered and provided by a physician, a nurse practitioner or a midwife, who has examined the patient and with whom the patient has a substantial and ongoing relationship. Patient specific health information and/or medical data may be received at

a distant site by means of remote patient monitoring by a registered nurse, licensed pursuant to Education Law.

Providers eligible for reimbursement include physicians, physician assistants, dentists, nurse practitioners, podiatrists, optometrists, psychologists, social workers, speech pathologists, physical therapists, occupational therapists, audiologists, midwives, certified diabetes educators, certified asthma educators, genetic counselors, hospitals, home care, and hospices. In addition, a registered nurse may be reimbursed when receiving patient data by means of Remote Patient Monitoring (RPM).

Regulations related to Medicaid reimbursement under the telehealth reimbursement law are currently under development.

74. Q. What telehealth services does Medicaid currently cover?

A. Telemedicine (defined as the use of interactive audio and video technology to support real-time patient care) has been covered by Fee for Service Medicaid in specific settings and by specific provider types since September 2006. Coverage was expanded in February 2010, October 2011 and March 2015 to enable greater access to specific provider types in short supply across New York State.

More information can be found here:
http://www.health.ny.gov/health_care/medicaid/program/update/2015/2015-03.htm

Regulations pertaining to Medicaid coverage of telehealth services are under development.

Other

75. Q. Are there any other alternatives to support the integration of care?

A. Yes. Staff leasing agreements may be used to help facilitate the provision of integrated care. For example, a clinic licensed by DOH pursuant to PHL Article 28 that would like to provide MH services could contract with a provider licensed by OMH pursuant to MHL Article 31 for clinical staff to furnish such services on its behalf. The DOH licensed clinic would reimburse the OMH licensed provider for services rendered. The DOH licensed clinic would be financially and legally responsible for the services provided by the OMH licensed provider staff. The DOH licensed clinic also would be the provider of record and responsible for submitting any claims for services rendered.

In addition, the agencies are working on guidance to be issued shortly for multiple providers that are interested in sharing licensed clinical space and carrying out programmatic activities for purposes of offering integrated services.

76. Q. When will CMS provide clarification regarding shared space?

A. DOH has been in discussions with CMS in regards to shared space, and we are hoping to release guidance for providers in the near future.

77. Q. Is there a waiver available for co-located space/services for providers other than FQHCs and outpatient hospital clinics?

A. There is currently no waiver related to co-location/shared space. DOH, OMH, and OASAS will be releasing guidance for providers looking to enter into these arrangements in the future.

78. Q. If an MHL Article 31 clinic is planning on co-locating a site in an FQHC, is that considered "shared space" and is it allowed?

A. Two or more entities that are located at the same address, but each with its own distinct physical space, can be considered co-location. An example of this would be an office building with a common atrium and elevator bank that houses multiple providers, each in their own suites. Co-located providers may only share common areas (i.e., public spaces such as lobbies that are not areas where patients are waiting for care, non-patient restrooms, and public paths of travel such as elevators and corridors through non-clinical areas) and do not share any staff or other space. The Department hopes to release guidance on shared space in the near future. However, there are numerous options providers already have for integrating care: the existing 2008 Licensure Threshold, DSRIP Project3.a.i Licensure Threshold, IOS, Multiple Licenses/Certification and, as always, providers may contract for services.

79. Q. What modifiers should be used for PHL Article 28 and MHL Article 31 facilities for Screening, Brief Intervention, and Referral to Treatment (SBIRT) services?

A. Practitioners should bill for SBIRT following the April 2016 Medicaid Update, pages 11 - 15, using the appropriate H or Z Healthcare Common Procedure Codes System (HCPCS) procedure codes. The claim will require a diagnosis code.

More information can be found here:
http://www.health.ny.gov/health_care/medicaid/program/update/2016/2016-04.htm

Billing – DSRIP Project 3.a.i Licensure Threshold

80. Q. Does a provider need formal approval of the DSRIP Project 3.a.i Licensure Threshold (up to 49% of visits) before using the new rate codes?

A. Yes, if the provider will exceed the 2008 standard threshold limits, the provider would need to seek formal approval for DSRIP 3.a.i licensure thresholds.

More information can be found here: https://www.health.ny.gov/press/releases/2008/2008-03-04_con_reform_ambulatory_care_services.htm

DOH has provided PPS Leads with an excel-based tracker document (Regulatory Waiver Tracking Tool) to input the details needed to identify providers participating in the project. The specific Regulatory Waiver and Project Tracking Tool for each PPS is located within the Regulatory Waiver subfolder within the PPS' Digital Library. Information needed will include:

- Provider Name
- Provider ID
- Facility License Type
- National Provider Identifier (NPI)
- Operating Certificate Number
- Locator Code
- Postal Code (zip code + 4)

PPS Leads will be asked to complete and return the tracker document included in the communication for all DSRIP Project 3.a.i provider categories by November 8, 2016. Once the Department has this information, rate codes will be assigned.

81. Q. Where can providers access the Integrated Rate Codes?

A. PPS Leads will be asked to complete and return a regulatory waiver tracker document (Regulatory Waiver Tracking Tool), which includes documentation for all DSRIP Project 3.a.i provider categories by November 8, 2016. Once the Department has this information, DSRIP Project 3.a.i specific rate codes will be assigned. IOS rate codes are the following:

PHL Article 28 IOS rate codes:

- 1594: DOH OPD INTEGRATED OUTPT SVC
- 1597: DOH DTC INTEGRATED OUTPT SVC
- FQHCs (Article 28) should bill Prospective Payment System (PPS) rate for all services provided to patient within the same day

MHL Article 31 IOS rate codes:

- 1122: OMH OPD INTEGRATED OUTPT SVC
- 1124: OMH OPD INTEGRATED OUTPT SVC-SED
- 1480: OMH DTC INTEGRATED OUTPT SVC
- 1483: OMH DTC INTEGRATED OUTPT SVC

MHL Article 32 IOS rate codes:

- 1130: OASAS DTC MMTP INTEGRATED OUTPT SVC
- 1132: OASAS OPD INTEGRATED OUTPT SVC
- 1134: OASAS OPD MMTP INTEGRATED OUTPT SVC
- 1486: OASAS DTC INTEGRATED OUTPT SVC

82. Q. When will the APG Rate Code be loaded into the Computer Science Corp (CSC) Medicaid System?

A. DSRIP Rate Codes will be finalized and should be available to providers tentatively in Fall 2016. IOS Rate Codes are established and available. The Department requires site-specific information from integrated services providers (via the Regulatory Waiver Tracking Tool) in order to load the rate codes appropriately. Until this occurs, providers should follow the normal APG billing process. As an alternative, an integrated services provider could bill the two integrated services and then submit a claim adjustment using the newly assigned rate code. When billing two E&Ms on the same date of service, the primary diagnosis should reflect the services provided under the first reported E&M, and the second diagnosis should reflect the services provided under the second reported E&M, using an XP modifier on the second E&M.

83. Q. If a provider licensed by DOH pursuant to PHL Article 28 utilizes the DSRIP Project 3.a.i Licensure Threshold in development of a DSRIP project, can such provider provide the MH and/or SUD services (and bill) with a Licensed Mental Health Counselor (LMHC), Licensed Marriage and Family Therapist (LMFT), etc. as opposed to Licensed Clinical Social Worker (LCSW) or PhD staff?

A. A practitioner providing MH and/or SUD services in a DOH licensed clinic must be a licensed psychiatrist, psychologist, psychiatric nurse practitioner, or an LCSW. Services provided by an LCSW in a DOH licensed clinic are limited to patients who are under age 21 or pregnant women up to 60 days postpartum (based on the date of delivery or end of pregnancy). Licensed MH counselors, licensed marriage and family therapists, and PhD staff are not recognized providers in the PHL Article 28 licensed setting.

84. Q. Under DSRIP, can a provider request a waiver of 10 NYCRR § 86-4.9 to allow for reimbursement of two visits on one day?

A. No regulatory waiver will be provided. FQHCs that have not opted into APGs operate under the PPS rate. DOH sets the PPS rate using the methodology established under federal law. The PPS methodology, including the "per visit basis," is established under federal law and DOH does not have the authority to waive federal rules.

85. Q. What are the pros and cons of billing under DOH vs. OMH for integrated services?

A. The primary biller of same-day, integrated services is the host site. Currently, a provider may opt to pursue the integration of PC, MH, and/or SUD services by obtaining a separate license or certificate from each corresponding agency (DOH, OMH or OASAS, as appropriate to the additional services).

Facilities should consider the following in their decision-making process: programmatic (full integration), fiscal (differential in APG base rates) and administrative (staffing, record keeping and certification requirements).

A provider licensed under PHL Article 28 that does not have full MHL Article 31 certification, is offering MH services, must be licensed under MHL Article 31 by OMH **if more than 10,000 annual visits for MH services or more than 30 percent of its total annual visits are for MH services.**

A provider licensed by OMH under MHL Article 31 to provide outpatient MH services or certified by OASAS under MHL Article 32 to provide outpatient SUD services must obtain PHL Article 28 licensure by DOH if more than 5 percent of total annual visits are for PC services or if any visits are for dental services.

86. Q. Under DSRIP Project 3.a.i, Model 1, does the PCP have to submit the claim for a medical service provided by a BH provider under their MHL Article 31 or 32? Can BH providers bill separately for services within a PCP site as one of their billing locations?

A. As an Article 28 integrated service provider relative to Model 1 of DSRIP Project 3.a.i, a single APG claim is submitted to Medicaid and all the services provided are reported on the APG claim. The BH provider cannot bill separately for services within a PCP site as one of its billing locations. If a host PHL Article 28 provider is not an integrated services provider AND is contracting with a BH provider, the host Article 28 provider would bill for services rendered by the contracted BH provider.

87. Q. Under DSRIP Project 3.a.i, Model 2, does the BH provider have to submit the claim for a medical service provided by a PCP under their MHL Article 31 or 32? Can PCPs bill separately for medical services that are provided within a BH provider site especially if they add the BH site as one of their billing locations?

A. The MHL Article 31 or 32 must submit the claim as the host site, when PC is integrated at one of the BH sites. Providers integrating services under the DSRIP 3.a.i Licensure Threshold should submit one claim for each visit with all the procedures/services rendered on the date of service (e.g., BH services and PC services). The PCP site in a host MHL Article 31 or 32 facility should not submit a separate claim to Medicaid. The APG payment to an MHL Article 31 or 32 facility includes all professional services.

88. Q. Are there specific procedure codes for physical health services that are required in a BH clinic setting?

A. No formal list will be distributed. Included services may include E&M codes, prevention codes, screening or counseling services included in the US Preventive Services Task Force (USPSTF) list of

A and B recommendations, and immunizations listed by the Advisory Committee on Immunization Practices (ACIP). Model 2 of DSRIP Project 3.a.i requires comprehensive PC services at the Article 31 facility, not just health screening and monitoring services.

89. Q. How should an MHL Article 31 licensed provider bill for the provision of PC services under the DSRIP Project 3.a.i. Licensure Threshold construct?

A. New rate codes are being established for this purpose. This will involve changing the definition of the hospital-based rate codes 1110 and 1112 to say OMH – HOSP, rather than OMH – OPD to avoid confusion.

Setting	State Agency	Category of Service (COS)	Rate Code Description	Rate Code
DTC	OMH	0160	OMH DTC APG ART 31 INTEGRATED SVC (DSRIP)	1106
Hospital	OMH	0287	OMH OPD APG ART 31 INTEGRATED SVC (DSRIP)	1110

Billing – Integrated Outpatient Services Regulations

90. Q. Under the IOS regulations, may a provider bill the current MH patients with the OASAS rates as with the incoming patients seeking MH services?

A. A licensed or certified provider approved under the IOS regulations to provide integrated care services will be issued an integrated services rate code that will be reimbursed through the APGs. All services should be billed under the integrated services rate code.

91. Q. Would a PHL Article 28 facility be eligible for the additional payment for E&M if they are integrating BH?

A. For PHL Article 28 clinics, all services provided should be billed on one claim. Payment for integrated services, regardless of certification (DSRIP Project 3.a.i, IOS certification) is the same, i.e., the APG base rate will remain the same. Provider facilities will be reimbursed in full when a second E&M is billed for the same recipient for the same date of services for care delivered in an integrated setting. Additionally, the 10% discount previously applied to Behavioral Health procedures has been eliminated. When billing two E&Ms on the same date of service, the primary diagnosis should reflect the services provided under the first reported E&M, and the second diagnosis should reflect the services provided under the second reported E&M, using an XP modifier on the second E&M. IOS rate codes are the following:

Article 28 IOS rate codes:

- 1594: DOH OPD IOS
- 1597: DOH DTC IOS
- FQHCs (Article 28) should bill Prospective Payment System (PPS) rate for all services provided to patient within the same day

Article 31 IOS rate codes:

- 1122: OMH OPD IS Dual License
- 1124: OMH OPD IS SED Dual License
- 1480: OMH DTC IS Dual License
- 1483: OMH DTC IS SED Dual License

Article 32 IOS rate codes:

- 1130: OASAS DTC MMTP IOS

- 1132: OASAS OPD IOS
- 1134: OASAS OPD MMTP IOS
- 1486: OASAS DTC IOS

92. Q. What are the BH integrated rate codes? How and when will an agency know what the new integrated APG is their designation?

A. The Department is presently working on activating the DSRIP rate codes and should be available to providers tentatively in Fall 2016. The codes will be assigned to providers as appropriate. Providers will be notified by the department when the codes have been activated.

Payment for integrated services, regardless of certification (DSRIP Project 3.a.i, IOS certification) is the same, i.e., the APG base rate will remain the same. Provider facilities will be reimbursed in full when a second E&M is billed for the same recipient for the same date of services for care delivered in an integrated setting. Additionally, the 10% discount previously applied to BH procedures has been eliminated. When billing two E&Ms on the same date of service, the primary diagnosis should reflect the services provided under the first reported E&M, and the second diagnosis should reflect the services provided under the second reported E&M, using an XP modifier on the second E&M. IOS rate codes are as following:

DSRIP rate codes:

- 1102-DOH DTC APG ART 28 INTEGRATED SVC (DSRIP)
- 1104- DOH OPD APG ART 28 INTEGRATED SVC (DSRIP)
- 1106-OMH DTC APG ART 31 INTEGRATED SVC (DSRIP)
- 1108- OMH DTC APG ART 31 INTEGRATED SVC-SED (DSRIP)
- 1110- OMH OPD APG ART 31 INTEGRATED SVC (DSRIP)
- 1112- OMH OPD APG ART 31 INTEGRATED SVC-SED (DSRIP)
- 1114- OASAS DTC APG ART 32 INTEGRATED SVC (DSRIP)
- 1116-OASAS DTC APG MMTP INTEGRATED SVC (DSRIP)
- 1118- OASAS OPD APG ART 32 INTEGRATED SVC (DSRIP)
- 1120- OASAS OPD APG MMTP INTEGRATED SVC (DSRIP)

IOS rate codes:

- 1480 - OMH DTC APG ART 31 INTEGRATED OUTPATIENT SVC
- 1483 - OMH DTC APG ART 31 INTEGRATED OUTPATIENT SVC-SED
- 1486 - OASAS DTC APG ART 32 INTEGRATED OUTPATIENT SVC
- 1594 - DOH OPD APG ART 28 INTEGRATED OUTPATIENT SVC
- 1597 - DOH DTC APG ART 28 INTEGRATED OUTPATIENT SVC
- 1122 - OMH OPD APG ART 31 INTEGRATED OUTPATIENT SVC
- 1124 - OMH OPD APG ART 31 INTEGRATED OUTPATIENT SVC-SED
- 1130 - OASAS DTC APG MMTP INTEGRATED OUTPATIENT SVC
- 1132 - OASAS OPD APG ART 32 INTEGRATED OUTPATIENT SVC
- 1134 - OASAS OPD APG MMTP INTEGRATED OUTPATIENT SVC

93. Q. What are the differences between integrated billing codes 1480 and 1122 "OMH APG Article 31 Integrated Service"?

A. The difference between the two codes (1122 and 1480) is the setting in which the service took place. 1122 is for a hospital outpatient department setting, while 1480 is for D&TC setting.

94. Q. Under the IOS regulations, will the MH services be billable to Medicare under the OASAS billing guidelines?

A. The IOS regulations (10 NYCRR Part 404, 14 NYCRR Part 598 and 14 NYCRR 825) apply to Medicaid-only patients. When services are provided to a Medicare/Medicaid dually eligible patient, Medicaid is the secondary payor and defers to the Medicare coverage and payment policy. If the host site is a PHL Article 28 clinic, Medicaid will reimburse providers the lower of the difference between the Medicare paid amount and the Medicaid rate or the Medicare Part B coinsurance amount for integrated care services. If the host site is a MHL Article 31 or MHL Article 32 clinic, Medicaid will pay the difference between the Medicare payment and the Medicaid rate.

95. Q. Under the IOS regulations, should all MH services be billed with all payer sources under the OASAS rates; i.e., Medicaid managed care, insurance, etc.?

A. Medicaid is always the payor of last resort. Providers must bill all commercial insurance prior to billing Medicaid. Medicaid will pay the lower of the third party patient responsibility or the difference between the third party paid amount and the integrated services APG rate.

96. Q. How does provider billing work for hospital-based OASAS certified programs?

A. Hospital-based programs receive a specific IOS rate code to be used for all services delivered at an approved site. Billing is via APGs in accordance with the OASAS clinical billing and guidance manual.

97. Q. Are OMH BH billing codes used in clinics licensed by DOH pursuant to PHL Article 28 the same as those used in the clinics licensed by OMH pursuant to MHL Article 31?

A. As stated in the response to FAQ #90, approved integrated services providers are assigned APG Medicaid billing rate codes which are to be used by the integrated services provider at the host site.

98. Q. If a provider licensed by DOH pursuant to PHL Article 28 has been approved to provide integrated services under 10 NYCRR Part 404, can such provider bill for BH services provided by a nurse practitioner?

A. A PC host model provider approved to provide integrated care services may bill for BH services provided by a nurse practitioner.

99. Q. If a provider licensed pursuant to PHL Article 28 has been approved to add MH services under 10 NYCRR Part 404, can such provider bill for group psychotherapy services?

A. A PC host model provider approved to deliver MH services is reimbursed through APGs. The APG grouper reimburses for individual and group psychotherapy.

100. Q. Under the IOS regulations, does a provider licensed by DOH pursuant to PHL Article 28 need to be licensed by OMH in order to bill for MH services?

A. Upon DOH and OMH approval as an integrated services provider, the PC host site can bill for MH services. In the absence of approval to provide integrated care services, the provider licensed by DOH pursuant to PHL Article 28 is limited to the Licensure Thresholds described in FAQ #3.

101. Q. Can a provider certified by OASAS pursuant to MHL Article 32 that has been approved to add MH services under 14 NYCRR 825 bill for SUD services provided by a licensed social worker?

A. An OASAS certified provider that has been approved to add MH services under 14 NYCRR 825 can bill for SUD services provided by a LCSW or LMSW

102. Q. Do managed care contracts have to be individually negotiated with each company or are these requirements mandated?

A. Providers treating patients who are in a managed care plan are subject to the contract terms and conditions that have been negotiated with the plan. Some plan contract terms are mandated terms that are the result of requirements in the contract between the State and Managed Care Organizations (MCOs) (e.g. MCOs must pay OMH licensed and OASAS certified providers at the State rate.)

103. Q. Are managed care plans required to follow both the clinical and billing regulations? If they don't, then what recourse do facilities have to remedy the situation?

A. Managed care plans are bound by the terms contained in the contract they have with the State. If plans do not follow these requirements, providers and plan members should file all necessary appeals with the managed care plan.

104. Q. If group psychotherapy services can be billed by MHL Article 31 licensed providers, does that mean only an MD can provide these services?

A. Group psychotherapy services billed by a provider licensed by OMH pursuant to MHL Article 31 can be provided by any practitioner recognized under OMH regulations, e.g., licensed psychologist, licensed clinical social worker, licensed master social worker, licensed MH counselor, etc.

105. Q. Per Medicare regulations, is a provider licensed by DOH pursuant to PHL Article 28 able to bill for MH services provided by a licensed clinical social worker?

A. Medicaid will reimburse a provider licensed by DOH pursuant to PHL Article 28 for MH services provided by a LCSW provided to a Medicare/Medicaid dually eligible recipient to the extent permitted by cost sharing statute, i.e., Medicaid will pay full annual Medicare Part B deductible amounts and Medicare Part B coinsurance amounts up to the Medicaid rate.

106. Q. Do FQHC Prospective Payment Systems (PPS) rates cover all services, even if the patient saw both a family physician and a psychiatrist on the same day? Would the FQHC submit one bill?

A. All services rendered in a FQHC on the same day are covered under the PPS rate. Two separate services would not be billable in this situation. One PPS rate can be billed for these distinct services on the same day.

Billing – Other

107. Q. To what extent can a clinic licensed by DOH pursuant to PHL Article 28 bill for MH services provided by licensed social workers?

A. Consistent with section 2807(2-a)(f)(ii)(c) of the PHL, Medicaid reimbursement is available for individual MH counseling services provided by a LCSW or a Licensed Master Social Worker (LMSW) under the supervision of a LCSW, psychologist or psychiatrist in PHL Article 28 licensed outpatient hospital clinics (OPDs) and freestanding D&TCs, including school based health centers (SBHCs). Such services, however, are reimbursable only when provided to enrollees under the age of 21 and to pregnant women up to 60 days postpartum (based on the date of delivery or end of pregnancy). In order to qualify as a billable Medicaid service, claims for services rendered to pregnant women are required to have a primary or secondary diagnosis of pregnancy and claims for services rendered to women post-pregnancy are required to have a primary or secondary diagnosis of postpartum depression.

LCSW/LMSW Mental Health Counseling Medicaid Rate Codes

Individual MH counseling services provided by a LCSW or LMSW to enrollees under the age of 21 and to pregnant women up to 60 days postpartum (based on the date of delivery or end of pregnancy) should be billed under the following rate codes (not APGs):

- 4257 (SBHCs 3257) Individual Brief Counseling (psychotherapy which is insight oriented, behavior modifying and/or supportive, approximately 20-30 minutes face-to-face with the patient).
- 4258 (SBHCs 3258) Individual Comprehensive Counseling (psychotherapy which is insight oriented, behavior modifying and/or supportive, approximately 45-50 minutes face-to-face with patient).
- 4259 (SBHCs 3259) Family Counseling (psychotherapy with or without patient).

Applicability

This policy applies to PHL Article 28 licensed outpatient providers that integrate services under the Licensure Thresholds, DSRIP Project 3.1.i Licensure Threshold or the IOS regulations.

Exceptions

Population limits placed on Medicaid reimbursement for MH counseling provided by LCSWs or LMSWs are not applicable to:

- **Dually Licensed Clinics:** A dually licensed PHL Article 28 licensed clinic is a clinic that also possesses a MHL Article 31 license and has the appropriate certification listed on its operating certificate (i.e., “Certified Mental Health O/P”). This certification means that the operator also possesses an MHL Article 31 operating certificate from OMH for the site and is permitted to render any service and/or serve any population authorized under its MHL Article 31 license. A dually licensed provider should bill APGs utilizing Current Procedure Terminology (CPT) codes instead of LCSW/LMSW MH counseling Medicaid rate codes.
- **Federally Designated Health Clinics:** A federally designated health clinic means a FQHC, a FQHC “look-alike” (a clinic that meet FQHC requirements but is not receiving a grant under Section 330 of the Public Health Service Act) or a Rural Health Clinic (RHC) that is certified by the Centers for Medicare and Medicaid Services (CMS).

MH counseling services provided by a LCSW or a LMSW are not subject to population limits (e.g. age) placed on Medicaid reimbursement since such services are covered under the all-inclusive Prospective Payment System (PPS) rate. Federally designated health clinics must bill their all-inclusive PPS rate for individual therapy and a lesser rate per recipient for group therapy. FQHCs can bill one PPS rate for all services on the same day. The FQHC rate codes, which are used by all federally designated health clinics, are:

- 4011 FQHC Group Psychotherapy, or
- 4013 FQHC Individual Threshold Visit

Billing for services rendered at part-time clinics will not be allowed.

- **Collaborative Care Program:** Collaborative Care is an evidence- based model of BH integration to detecting and treating common MH conditions such as depression and anxiety in PC settings. Collaborative Care focuses on defined patient populations tracked in a registry, measurement-based treatment to target. Trained PCPs and embedded BH professionals provide evidence-based medication and/or psychosocial treatments, supported by regular psychiatric case consultation and treatment adjustment for patients who are not improving as expected.

  As part of the NYS Medicaid Collaborative Care program, participating academic medical center-affiliated PC practices offer care management services provided by psychiatrists, nurse practitioners, psychologists, LCSWs or LMSWs to patients diagnosed with depression (patients must have a minimal score on an approved psychometric measure). These patients are monitored on a monthly basis for up to 12 months.

  Care management services provided by a psychiatrist, a nurse practitioner or a psychologist are billable under the APG rates. However, care management services provided by a LCSW or a LMSW are not billable under the APG rates, nor are they billable under the LCSW/LMSW MH counseling Medicaid rate codes. The services are billable as an indirect part of the collaborative care rate, which is only provided to the academic medical centers that are participating in the collaborative care program. Furthermore, care management services provided by a LCSW or a LMSW may be provided, in any site that is authorized, to eligible patients regardless of their age or whether they are pregnant.

108. Q. May a PHL Article 28 provider negotiate with a Medicaid MCO to cover a LCSW/LMSW providing services?

A. Yes, a provider could negotiate with a Medicaid MCO to cover these services. The statutory prohibition for LCSW/LMSW billing relates to Medicaid coverage for those over the age of 21 who are not pregnant. Managed Care capitated payment does not include LCSW/LMSW services for individuals other than children under age 21 and pregnant women.

109. Q. If a clinic is dually licensed as PHL Article 28 D&TC and MHL Article 31, can the patient receive billable services from the D&TC and the MH Clinic on the same day?

A. If a patient was seen in a PHL Article 28 and MHL Article 31 on the same day, both clinics can bill Medicaid.

Appendix: Acronyms

Approached to Integrated Care FAQ Acronyms	
Acronym	**Definition**
BH	Behavioral Health
CON	Certificate of Need
COS	Category of Service
D&TC	Diagnostic & Treatment Center
DOH	Department of Health
DSRIP	Delivery System Reform Incentive Payment
FAQs	Frequently Asked Questions
FQHC	Federally Qualified Health Center
IMPACT	Improving Mood - Promoting Access to Collaborative Treatment
IOS	Integrated Outpatient Services
LCSW	Licensed Clinical Social Worker
LGU	Local Government Unit
LMFT	Licensed Marriage and Family Therapist
LMHC	Licensed Mental Health Counselor
LMSW	Licensed Master Social Worker
LRA	Limited Review Application
MCO	Managed Care Organization
MH	Mental Health
MHL	Mental Hygiene Law
NYS	New York State
OASAS	New York State Office of Alcoholism and Substance Abuse Services
OMH	New York State Office of Mental Health
OPDs	Outpatient Hospital Clinics
PC	Primary Care
PCMH	Patient Centered Medical Home
PCP	Primary Care Provider
PHL	Public Health Law
PPS	Performing Provider System
PPS*	Prospective Payment System *(*always written out in full in document)*
SBHC	School Based Health Centers
SUD	Substance Use Disorder
TCM	Targeted Case Management