

**NEW YORK STATE DEPARTMENT OF HEALTH  
NEW YORK STATE OFFICE OF MENTAL HEALTH  
NEW YORK STATE OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE  
SERVICES**

**STATEWIDE GUIDANCE ON SPACE ARRANGEMENTS  
BETWEEN TWO OR MORE PROVIDERS  
October 18, 2016**

**I. OVERVIEW**

As a means for promoting better coordination of service delivery for persons with multiple needs, the Department of Health (DOH), the Office of Mental Health (OMH) and the Office of Alcoholism and Substance Abuse Services (OASAS) are issuing this guidance to providers licensed pursuant to Public Health Law (PHL) Article 28, licensed pursuant to Mental Hygiene Law (MHL) Article 31 or certified pursuant to MHL Article 32 that wish to integrate services through a “shared space” arrangement with other licensed or certified providers or with private medical practices. This document describes the application process for various types of shared space arrangements between two or more providers, which are enumerated in Appendix A.

A provider should also consult the Frequently Asked Questions (FAQs) document related to integrated care approaches issued by DOH, OMH and OASAS for additional options available to a provider that wishes to integrate primary care and behavioral health (mental health and/or substance use disorder) services. The FAQs cover the following approaches:

- Licensure Thresholds;
- DSRIP Project 3.a.i Licensure Threshold;
- Integrated Outpatient Services Regulations;
- Collaborative Care; and
- Multiple Licenses.

The FAQs can be found here:

[https://www.health.ny.gov/health\\_care/medicaid/redesign/dsrp/2016/2016-01\\_integrated\\_care\\_faqs.htm](https://www.health.ny.gov/health_care/medicaid/redesign/dsrp/2016/2016-01_integrated_care_faqs.htm)

In addition, a provider could consider staff leasing agreements, with set schedules/shifts and a clear delineation for which provider staff are working for at what time, to help support the provision of integrated care. An example of this arrangement includes subcontracting for a psychiatrist to work two half-day sessions per week in their primary care practice. In this scenario, as with the options outlined in the FAQ document related to integrated care approaches, a single provider is responsible for all services.

Nothing in this document relieves a provider from any responsibility for compliance with federal laws and regulations governing space arrangements. Nothing in this document is intended to substitute, add, or amend any federal law or regulation.

Although the term “federally designated” is not defined in statute or regulations, for purposes of this guidance document, DOH, OMH and OASAS will use the term to mean an entity that has entered into an agreement with CMS to participate in the Medicare program to receive reimbursement for the services provided by the facility. Federally designated providers include FQHCs, RHCs, ACSs, Hospitals, Hospital extension clinics, RHCFs and ESRDs

## **II. MORE THAN ONE PROVIDER: CO-LOCATION AND SHARED SPACE**

Although the terms “co-location” and “shared space” are not defined in statute or regulations, for purposes of this guidance document, DOH, OMH and OASAS will use the terms as follows:

### **A. Co-location**

Co-location is a permissible option consisting of two or more entities that are located at the same address but each has its own distinct physical space. It is permissible provided the following:

- Unless otherwise prohibited, when providers are co-located, public space within the building may be accessible to patients of all providers (e.g., a building may have shared entrances and exits, atria, elevators and staircases). Corridors or hallways that lead to separate providers may be available to all co-located providers as long as an individual does not need to travel through the clinical space of one provider to get to another provider.
- For federally designated providers, waiting rooms may not be shared. CMS has indicated that common waiting rooms with separate intake desks may be approved on a case-by-case basis.
- Providers that are New York licensed or certified and are not federally designated may share waiting rooms provided patient privacy is protected, there is clear signage and patient awareness of who is providing their care, and the providers are in compliance with any other federal or state requirements. These providers may share some resources, such as telephone and receptionist services, but must maintain accurate records to ensure clarity for any costs claimed and duplicate reimbursement does not occur.

- No commingling or sharing of clinical staff is permitted. Individuals may be employees of both providers, but their schedules must be separate and not overlapping between entities.
- Staff are not allowed to work simultaneously for more than one provider. Typically, staff such as maintenance or security work for the landlord and provide a contracted service to the tenant.
- A prospective provider that would like to establish a new facility, or a licensed or certified provider that would like to add a location off the campus of the main location, at a location where other providers will be co-located, must submit the appropriate licensure or certification application as required by the licensing/certifying agencies and obtain the appropriate approvals.
- Each co-located provider must independently comply with federal and state requirements (e.g., each provider must have a governing body that is separate from the governing body of the other provider(s) occupying space in the same building, clinical and non-clinical administrative staff may not work for more than one provider simultaneously, providers must maintain separate operations/processes, etc.).
- Providers participating in DSRIP Project 3.a.i should refer to Appendix C for additional guidelines and requirements related to co-location and shared space.

Examples of co-location include:

- An office building with a common atrium and elevator bank that houses multiple providers, each in their own suites.
- The “medical village” concept as a model for an “integrated delivery system.”
- A general hospital reallocating previously used space for another purpose and leasing or selling the space to another provider for use 24 X 7 to “co-locate” within such space.

## **B. Shared Space**

For purposes of this document, “shared space” is space occupied by one provider, a portion of which is leased to or otherwise used by another provider, or space which is leased or purchased by at least two providers. “Shared space” should be distinguished from “co-location.” Shared space may be “temporally distinct,” meaning the physical space may be shared at different times (*i.e.*, providers’ hours of operation do not overlap), or may be used “concurrently” (*i.e.*,

the providers have concurrent or overlapping hours of operation). Physical space can include both clinical space, such as an examination room, and non-clinical space, such as a shared waiting room, shared bathroom off the waiting area or shared reception area, to the extent permissible under federal and state rules.

Providers that are New York State licensed or certified and are not federally designated may be approved to share resources such as waiting rooms, telephones, and various services. There must be strict adherence to accurate records, which is the sole responsibility of the providers, to assure all costs are allocated appropriately, patient privacy is protected, and patients are aware of who is providing their care at all times. In addition to sharing physical space, shared space arrangements may include the sharing of clinical equipment to the extent permissible under applicable Federal and State rules.

This guidance sets forth the conditions that must be met in order to share licensed or certified space. It also sets forth conditions for a licensed or certified provider to share space with a private medical practice. Appendix A outlines the various shared space scenarios. Providers participating in DSRIP Project 3.a.i should refer to Appendix C for additional guidelines and requirements.

Examples of shared space include:

- An FQHC that is open Monday, Wednesday, and Friday and leases their space to a private practice on Tuesdays and Thursdays.
- State licensed Article 28 (diagnostic and treatment center) and Article 31 clinic sharing a common waiting room and receptionist.
- A private practice and an Article 32 sharing a common waiting room and examination rooms.

It should be noted that providers that lease space to another licensed or certified provider or private medical practice may need to review whether a leasing arrangement could jeopardize their tax-exempt status, if applicable. It also should be noted that certain arrangements may implicate federal and state anti-kickback or self-referral laws. Medicaid providers that engage in practices prohibited under anti-kickback or self-referral rules are at substantial risk for exclusion from the Medicaid Program. Accordingly, providers may wish to consult with counsel.

### III. CO-LOCATION AND SHARED SPACE: BY PROVIDER TYPE

#### Federally Qualified Health Centers and Rural Health Clinics

- Federally Qualified Health Centers (FQHCs) and FQHC “look-alikes” (clinics that meet FQHC requirements but are not receiving a grant under Section 330 of the Public Health Service Act)
- Rural health clinics (RHCs)

#### Staff Leasing

- A provider could consider staff leasing agreements to help support the provision of integrated care. An example of this arrangement includes subcontracting for a psychiatrist to work two half-day sessions per week in their primary care practice.
- This must include set schedules/shifts and a clear delineation for when the psychiatrist is working for the FQHC. In this scenario, as with the options outlined in the FAQ document related to integrated care approaches, a single provider (the FQHC) is responsible for all services.

#### Co-location

- An RHC/FQHC may be co-located with/lease space to another entity provided that space is separate from RHC/FQHC space.
- CMS has indicated common waiting rooms with separate intake desks may be approved on a case by case basis.

#### Shared Space

- For RHCs/FQHCs, sharing of space with another entity is not prohibited. However, the space may not be shared during the RHC/FQHCs hours of operation. The same physical premises may be used by the RHC/FQHC and other entities, so long as they are separated in their usage by time (temporally distinct). *FQHC providers have asked for additional federal clarification on this issue, which we are seeking from CMS. Should that clarification differ from what is stated in this document, we will notify providers.*

#### Ambulatory Surgery Centers (ASCs)

#### Staff Leasing

- A provider could consider staff leasing agreements to help support the provision of integrated care. An example of this arrangement includes subcontracting for a psychiatrist to work two half-day sessions per week in their primary care practice.
- This must include set schedules/shifts and a clear delineation for when the psychiatrist is working for the FQHC. In this scenario, as with the options outlined in the FAQ document related to integrated care approaches, a single provider (the FQHC) is responsible for all services.

### **Co-location**

- ASCs may be co-located with another entity provided they do not share any common areas during hours of operation.

### **Shared Space**

- ASCs may share space with another entity provided it is temporally distinct at all times. In other words, the same physical premises may be used by the ASC and other entities, so long as they are separated in their usage by time. ASCs cannot share any physical space during its hours of operation.
- It is not permissible for an ASC during its hours of operation to “rent out” or otherwise make available an OR or procedure room, or other clinical space, to another provider or supplier, including a physician with an adjacent office.

### **Hospitals, Extension Clinics, RHCF, and ESRD**

- General hospitals, including extension clinics;
- Critical access hospitals (CAH);
- Residential health care facilities (RHCF); and
- End stage renal dialysis facilities (ESRD).

### **Staff Leasing**

- A provider could consider staff leasing agreements to help support the provision of integrated care. An example of this arrangement includes subcontracting for a psychiatrist to work two half-day sessions per week in their primary care practice.
- This must include set schedules/shifts and a clear delineation for when the psychiatrist is working for the FQHC. In this scenario, as with the options outlined in the FAQ document related to integrated care approaches, a single provider (the FQHC) is responsible for all services.

### **Co-location**

- These providers are able to co-locate assuming each provider independently complies with all federal, state or local laws, regulations and policies applicable to their establishment and operation separately (*e.g.*, governing body, physical space, staffing and operations/processes, etc.) or, if applicable, may integrate services under one of the other available approaches as described in the FAQ document referenced in Section I. As noted above, co-location consists of two or more different providers that are located in the same structure or on the same campus, but each with its own distinct physical space.
- Unless otherwise prohibited, when providers are co-located, public space within the building may be accessible to patients of all providers (*e.g.*, a building may have shared entrances and exits, atria, elevators and staircases). Corridors or hallways that lead to separate providers may be available to all co-located providers as long as an individual does not need to travel through the clinical space of one provider to get to another provider.

### **Shared Space**

- Federal policies do not allow these providers to share space in general but do allow for leased space that is under the control of the tenant 24/7 and that is physically accessible without passing through the clinical space of another provider.
- A hospital can lease or sell space to another entity for use 24/7 but cannot share space, temporally or otherwise.
- The certified hospital contains all departments, all locations, both inpatient and outpatient services, on and off campus.

### **Article 28 State Only Licensed/Certified Diagnostic and Treatment Centers (non-federally designated), Article 31 Clinics, and Article 32 Clinics**

#### **Staff Leasing**

- A provider could consider staff leasing agreements to help support the provision of integrated care. An example of this arrangement includes subcontracting for a psychiatrist to work two half-day sessions per week in their primary care practice.
- This must include set schedules/shifts and a clear delineation for when the psychiatrist is working for the FQHC. In this scenario, as with the options outlined in the FAQ document related to integrated care approaches, a single provider (the FQHC) is responsible for all services.

#### **Co-location**

- Providers that are licensed or certified by New York State and are not federally designated may be co-located with another provider. They may share waiting rooms provided patient privacy is protected, there is clear signage and patient awareness of who is providing their care, and are in compliance with any state requirements. These providers may share some resources, such as telephone and receptionist services, but must maintain accurate records to ensure clarity for any costs claimed and duplicate reimbursement does not occur.

#### **Shared Space**

- If neither provider holds a federal designation, the shared space may be temporally distinct or used concurrently. They may share waiting rooms provided patient privacy is protected, there is clear signage and patient awareness of who is providing their care, and are in compliance with any state requirements. Providers that share resources with another entity must maintain accurate records to ensure that all costs claimed are allocated appropriately to avoid duplicate reimbursement.

#### **IV. SHARED SPACE: LICENSURE AND CERTIFICATION**

Each provider proposing to share space must be licensed or certified to operate in the location in question, unless the provider is a private medical practice.

Nothing in this document relieves providers from any responsibility for compliance with laws or regulations governing DOH's Certificate of Need (CON), OMH's Prior Approval Review (PAR) or OASAS' certification requirements or other notice submission requirements. Applications may be approved contingent on any additional documentation needed to satisfy the appropriate State agencies, including executed lease agreements, management services agreements, staffing contracts, etc., and all other documentation required and acceptable to the Department.

#### **V. SHARED SPACE: APPLICATION PROCESS**

Each provider that wishes to certify clinical space inside space that is already occupied by one provider or at a site that is not yet occupied must submit an application to its state licensing or certifying agency to add an additional site. A private medical practice that wishes to share clinical space with a clinic licensed or certified by DOH, OMH or OASAS does not have to submit an application given they are not licensed or certified by the state. Also, please note that pursuant to 10 NYCRR 600.9(c), an individual, partnership or corporation which has not received establishment approval pursuant to Public Health Law Article 28 may not participate in the total gross income or net revenue of a medical facility.

The applicant must indicate on its licensing or certification application that it plans to share space with another provider, pursuant to a written shared space agreement between the providers. The application also must identify the provider and the provider's operating certificate number, as well as PFI/facility ID (if applicable).

In addition, the applicant must submit architectural/engineering drawings as required by its state licensing or certifying agency. Such drawings must meet submission requirements and clearly define the space to be occupied and common areas to be shared (delineate exclusive office space, interior office common space, building common space, clinical and non-clinical space, etc.).

If an applicant wishes to certify clinical space inside space that is already occupied by a provider, the designated space to be shared (not the entire space) must meet the relevant higher level physical plant standards and program space requirements, including standards for visual and acoustical privacy, of the state agency responsible for licensing or certifying the provider and, if applicable, federal conditions for participation, coverage or certification. For Life Safety Code requirements, providers must meet the higher level requirements relevant



for the provider type(s) fire wall to fire wall. In order to help ensure the safety of patients and personnel, and depending on the services to be provided, additional modifications may be needed outside of the designated shared space to address any impact to the facility or private medical practice that may compromise continued compliance with applicable laws and regulations. Any new outpatient clinic location must be able to meet the physical plant standards of the state agencies that license or certify the providers that will be sharing space.

Please note, a provider that already occupies the space to be shared does not need to submit an application unless the space to be shared will involve construction to initiate a service and ensure the safety of the physical plant. If any proposed shared space will require construction to initiate a service and ensure the safety of the physical plant, an application consistent with the requirements of each state agency may need to be submitted for architectural review. Review of such standards and requirements will be part of the licensure or certification application and any pre-opening survey, as applicable.

Any change from the approved application as to how the shared space is to be used will require notification to the agency that licenses the other provider.

## **VI. SHARED SPACE: SHARED SPACE AGREEMENT**

Licensed or certified providers, as described in Section III, that plan to share space with other licensed or certified providers, or private medical practices, should obtain a resolution signed by the board of directors, partners, LLC managers or members, or any other governing body of a legal entity, as applicable, authorizing the Shared Space Agreement and must document in writing the terms upon which they will share space. Appendix B outlines information that must be included as part of a Shared Space Agreement. The purpose of the Shared Space Agreement is to maximize patient safety and program efficiency, as well as to ensure confidentiality by identifying roles and responsibilities of each provider, outlining the clinical structure and clarifying commitments. However, a facility may not transfer responsibility for matters that each is otherwise required by applicable law and regulation to provide. Each provider must maintain a copy of the executed Shared Space Agreement and must be able to produce such agreement immediately upon request as required by the state agency responsible for licensing/certifying or oversight of the provider.

## **VII. SHARED SPACE: OPERATING CERTIFICATE**

Upon approval of the application and satisfaction of any contingency conditions related to the application, the applicable agency will issue an operating certificate for the site.

Such operating certificate must be conspicuously posted at the site.

## **VIII. SCOPE OF SERVICES**

Each licensed or certified provider may provide those services as authorized on its operating certificate and must comply with all applicable federal, state and local laws, regulations and policies.

It must be clear to patients at all times which provider is providing their care. Providers may wish to consult with counsel to ensure that they do not jeopardize their tax-exempt status, if applicable, or violate anti-kickback, Stark, antitrust or any other federal or state laws.

## **IX. MEDICAL RECORDS**

Providers in a shared space arrangement may share or integrate medical records and treatment information with each other to the extent permissible under federal and state laws. However, providers should only be able to access protected health information of their own patients. Each provider's patient records should be secured (e.g., locked file cabinet, password protected, etc.) from unauthorized use. Providers may use a shared Electronic Health Records platform, in accordance with the Health Insurance Portability and Accountability Act (HIPAA), however paper records may not be stored together.

In addition, providers must have the appropriate memorandum of understanding (MOU), Health Insurance Portability and Accountability Act (HIPAA) business associate agreement (BAA), qualified service organization agreement (QSOA) or similar agreement(s) in place in order to share medical records and treatment information, as needed for the care and treatment of shared patients.

To help facilitate sharing of information, providers may also wish to review consent and authorization forms, including an all-purpose form that can be used to disclose any medical records, a sample of which can be found here: <http://www.health.ny.gov/diseases/aids/providers/forms/informedconsent.htm>.

## **X. INSTITUTIONAL COST REPORT/CONSOLIDATED FISCAL REPORT**

Providers that lease their space to another licensed entity or private medical practice will need to adjust their annual Institutional Cost Report (ICR) to reflect any changes in their expenses and revenues, as well as statistical information. Providers required to submit Consolidated Fiscal Reports (CFRs) should notate any changes to expenses and revenues as indicated in the CFR Manual. OASAS funded providers should also consult the Administrative and Fiscal Guidelines (located at: <http://oasas.ny.gov/reggs/index.cfm>).

## **XI. REGULATORY OVERSIGHT**

Each licensed or certified provider will remain subject to oversight by the relevant state agency responsible for making sure the provider is in compliance with applicable laws and regulations.

- When one licensed or certified provider shares its space with another licensed or certified provider, or a private medical practice, the state agency that licensed or certified the provider that is sharing its space will inspect the entire site, including any shared space, consistent with its regulatory requirements. The provider that is sharing its space will be responsible for any deficiency cited in the licensed or certified space.
- The state agency that licenses or certifies the other provider also will inspect the shared space as delineated in the architectural/engineering drawings submitted with its application, consistent with that state agency's regulatory requirements. Such other provider will be responsible for any deficiency found in the shared space. The process is the same when a licensed or certified provider shares space originally occupied by a private medical practice.
- In instances where two or more providers (i.e. an Article 32 clinic and an Article 31 clinic) move into new space together, each state agency will be responsible for inspecting the entire site, consistent with its regulatory requirements. All providers may be cited for deficiencies found in the shared space. The state agency responsible for oversight will be responsible for citing the entity under its jurisdiction and/or advising the state agency that has jurisdiction over the other provider of the deficiency.
- When a shared space arrangement involves two or more providers licensed or certified by the same state agency, both providers may be cited for any deficiency found in the shared space.

The fact that no deficiencies were noted during a survey of one state agency will not influence any determination with respect to a survey pursuant to another state agency.

## **XII. REIMBURSEMENT**

Each provider in the Shared Space Agreement will be responsible for submitting claims to cover all the procedures/services rendered on a date of service by that provider. A clinic payment will be processed separately for each provider through the APG grouper/pricer and paid in accordance with the APG pricing

rules (packaging, discounting, bundling) associated with services normally billed under that APG rate code.

The Department will re-evaluate Medicaid billing policy after the first year of implementation to assess possible revisions to promote full service integration.

DSRIP billing guidance for providers in shared space arrangements will be found in Appendix C.

**Appendix A  
Shared Space Options**

<b>Scenarios</b>	<b>Shared Space</b>	<b>Application*</b>	<b>Regulatory Oversight</b>
<p>A licensed or certified provider (Provider 1) shares its space with another licensed or certified provider (Provider 2).</p>	<p>If one or both providers hold a Federal designation (FQHC, FQHC LA, RHC, ASC, OPT/SP, CORF), shared space must be temporally distinct.</p> <p>If neither provider holds a Federal designation, the shared space may be temporally distinct or used concurrently.</p>	<p>Provider 2 must submit an application to its licensing or certifying agency to add an additional site</p>	<p>The entire site, including the shared space, will be subject to oversight by the state agency that licensed or certified Provider 1.</p> <p>The shared space also will be subject to oversight by the state agency that licensed or certified Provider 2.</p>
<p>A licensed or certified provider (Provider 1) shares its space with a private medical practice (Provider 2).</p>	<p>If Provider 1 holds a Federal designation (FQHC, FQHC LA, RHC, ASC, OPT/SP, CORF), shared space must be temporally distinct.</p> <p>If Provider 1 does not hold a Federal designation, the shared space may be temporally distinct or used concurrently.</p>	<p>No application is required.</p>	<p>The entire site, including the shared space, will be subject to oversight by the state agency that licensed or certified Provider 1.</p>
<p>A private medical practice (Provider 1) shares its space with a licensed or certified provider (Provider 2).</p>	<p>If Provider 2 holds a Federal designation (FQHC, FQHC LA, RHC, ASC, OPT/SP, CORF), shared space must be temporally distinct.</p> <p>If Provider 2 does not hold a Federal designation, the shared space may be temporally distinct or used concurrently.</p>	<p>Provider 2 must submit an application to its licensing or certifying agency to add an additional site.</p>	<p>The shared space will be subject to oversight by the state agency that licensed or certified Provider 2.</p>

Scenarios	Shared Space	Application*	Regulatory Oversight
<p>A licensed or certified provider (Provider 1) and another licensed or certified provider (Provider 2) wishing to share space that is not yet occupied.</p>	<p>If one or both providers hold a Federal designation (FQHC, FQHC LA, RHC, ASC, OPT/SP, CORF), shared space must be temporally distinct.</p> <p>If neither provider holds a Federal designation, the shared space may be temporally distinct or used concurrently.</p>	<p>Provider 1 and Provider 2 must submit applications to their respective licensing or certifying agency to add an additional site.</p>	<p>The entire site, including the shared space, will be subject to oversight by the state agency that licensed or certified Provider 1 and the state agency that licensed or certified Provider 2.</p>
<p>A licensed or certified provider (Provider 1) and a private medical practice (Provider 2) wish to share space that is not yet occupied.</p>	<p>If Provider 1 holds a Federal designation (FQHC, FQHC LA, RHC, ASC, OPT/SP, CORF), shared space must be temporally distinct.</p> <p>If Provider 1 does not hold a Federal designation, the shared space may be temporally distinct or used concurrently.</p>	<p>Provider 1 must submit an application to its licensing or certifying agency to add an additional site.</p>	<p>The entire site, including the shared space, will be subject to oversight by the State agency that licensed or certified Provider 1.</p>

\* Please note that licensed or certified providers that plan to share space with other licensed or certified providers, or private medical practices, must document the terms upon which they will share space in writing. Each provider must maintain a copy of the executed Shared Space Agreement and must be able to produce such agreement immediately upon request as required by the state agency responsible for licensing/certifying or oversight of the provider.

## **Appendix B Shared Space Agreement**

A Shared Space Agreement must be developed in cooperation with providers involved and, at a minimum, include the following information:

1. Term
  - a. The commencement and expiration or termination dates.
2. Providers
  - a. The providers involved in the shared space proposal.
3. Services
  - a. List and describe the services to be provided in the shared space.
  - b. A description of how sharing space will enhance accessibility for patients.
  - c. A description of how the providers will coordinate services.
  - d. A description of shared patients.
  - e. Screening or other criteria that will guide treatment interventions for shared patients.
  - f. Procedures for coordinating or integrating treatment plans, referrals and follow-up.
  - g. A delineation of how equipment, supplies and other resources will be shared.
  - h. An agreement on the scope and frequency of communication and consultation pertaining to patient care, including face-to-face interactions and regular team meetings.
  - i. Any contracts or management service agreements for clinical or administrative services.
4. Space
  - a. Description of the space to be occupied and common areas to be shared, as well as schematics consistent with the approved application of such space (delineate exclusive office space, interior office common space, building common space, clinical and non-clinical space, etc.).

- b. The duration of time the premises and space will be used by each provider.
- c. Any space modifications that are required or planned and who will pay for them.
- d. A delineation of responsibilities for physical plant compliance with state regulations and building safety code and for day-to-day maintenance of shared space.

#### 5. Staffing

- a. The roles and responsibilities of the medical director(s).
- b. Medical staffing arrangements and roles, including clinical supervision.
- c. Non-medical staffing arrangements and roles.
- d. The extent to which staff will be shared, if permissible.
- e. The extent to which there will be training related to shared patients.

#### 6. Patient Notification

- a. A description of how providers will clearly identify themselves to the public and how patients will be informed that they are being seen by different providers, including use of clear signage in languages appropriate to the providers' patient populations that the providers are separate and distinct.

At all times, it must be clear to patients which provider is providing their care.

#### 7. Confidentiality

- a. A statement of the applicant's commitment to protect client confidentiality at all times.
- b. A description of how providers will share or integrate patient information and/or medical records with each other as necessary to coordinate patient care and treatment to the extent permissible under Federal and State laws.

#### 8. Accountability

- a. Affirmation that providers will share responsibility consistent with the Statewide Guidance on Shared Space Arrangements.
- b. A description of how providers will maintain appropriate oversight, accountability and responsibility of the services provided to their patients and responsibilities of each provider.



## **Appendix C**

### **Co-location/Shared Space and DSRIP Project 3.a.i**

The objective of DSRIP Project 3.a.i is to promote the integration of mental health and substance use disorder services with primary care for the purpose of ensuring coordination of care, through one of three models – Model 1 (PCMH), Model 2 (BH) or Model 3 (IMPACT). Each model is described further in the New York State Delivery System Reform Incentive Payment Program Project Toolkit (DSRIP Project Toolkit), which can be found here:

[http://www.health.ny.gov/health\\_care/medicaid/redesign/docs/dsrip\\_project\\_toolkit.pdf](http://www.health.ny.gov/health_care/medicaid/redesign/docs/dsrip_project_toolkit.pdf).

There are different approaches that can enable providers to implement Project 3.a.i. A single provider may choose to integrate primary care, mental health and/or substance use disorder services using one of the approaches described in the Frequently Asked Questions (FAQs) document issued by DOH, OMH and OASAS. (FAQs can be found here: [https://www.health.ny.gov/health\\_care/medicaid/redesign/dsrp/2016/2016-01\\_integrated\\_care\\_faqs.htm](https://www.health.ny.gov/health_care/medicaid/redesign/dsrp/2016/2016-01_integrated_care_faqs.htm)):

- Licensure Thresholds
- DSRIP Project 3.a.i Licensure Threshold
- Integrated Outpatient Services Regulations
- Collaborative Care
- Multiple Licenses

Performing Provider Systems (PPSs), as well as their provider partners that are pursuing Model 1 or Model 2, may also choose to allow two or more non-affiliated providers to collaborate in order to meet the integration requirements of Project 3.a.i through a shared space arrangement, incorporating the expertise of such providers in order to deliver integrated services.

Collaborating PPS provider partners that wish to enter into a shared space arrangement for purposes of Project 3.a.i must meet the requirements outlined in the Statewide Guidance on Shared Space Arrangements, including a Shared Space Agreement as required under Section VI of the Guidance document to identify roles and responsibilities of each provider, outline the clinical structure and to clarify commitments. The Shared Space Agreement, and all other relevant agreements, must be in place prior to commencing a shared space arrangement. This includes the appropriate memorandum of understanding (MOU), HIPAA business associate agreement (BAA), qualified service organization agreement (QSOA) or similar agreement(s) as needed for the care and treatment of shared patients.

Furthermore, as explained in the DSRIP Project Toolkit, providers pursuing Project 3.a.i Model 1 are required to be a 2014 NCQA Level 3 Patient-Centered Medical Home (PCMH)/Advanced Primary Care (APC) practice or must meet such standards by the

end of DSRIP Year 3. PCMH eligibility is conferred at the site level – meaning one recognition per address, one address per survey. All eligible clinicians at a site must apply together. It is anticipated that the components of Model 2 will mirror those of Model 1 with the exception that primary care services will be placed within behavioral health clinics. In addition, the DSRIP Project Toolkit sets out components that must be met. These activities should be documented as part of a PPS's quarterly report; however, please note, PPS Leads may not count patients seen in one Model as also seen in another Model. Actively engaged patient counts for each model are distinct based on the services provided at the host site. The host site for Model 1 is the Public Health Law Article 28 licensed provider or primary care provider. The host site for Model 2 is the Mental Hygiene Law (MHL) Article 31 licensed or MHL Article 32 certified provider.

### Reimbursement

- During the first year of implementation, each provider in the shared space arrangement will be responsible for submitting claims to cover all the procedures/services rendered on a date of service by that provider. A clinic payment will be processed separately for each provider through the APG grouper/pricer and paid in accordance with the APG pricing rules (packaging, discounting, bundling) associated with services normally billed under that APG rate code.
- Beginning with the second year of implementation, value based payments are eligible to be made to providers that achieve integrated electronic medical records for their shared patients.