NEW YORK STATE OF OPPORTUNITY. | Department of Health | Office of Mental Health | Office of Alcoholism and Substance Abuse Services

February 20, 2015

St. Barnabas Hospital (dba SBH Health System)
ST BARNABAS HOSPITAL
Leonard Walsh, C.E.O.
4422 Third Avenue
Bronx, NY 10457-2594

Dear Mr. Walsh:

The Department of Health (DOH), the Office of Mental Health (OMH), the Office of Alcoholism and Substance Abuse Services (OASAS) are pleased to respond to the request for waivers from certain regulatory requirements submitted under the Delivery System Reform Incentive Payment (DSRIP) Program. This letter responds to the request submitted by St. Barnabas Hospital in its capacity as lead for the St. Barnabas Hospital (dba SBH Health System) PPS under the Delivery System Reform Incentive Payment (DSRIP) Program.

Pursuant to Public Health Law (PHL) § 2807(20)(e) and (21)(e) and in connection with DSRIP Project Plans and projects under the Capital Restructuring Financing Program which are associated with DSRIP projects, DOH, OMH, and OASAS may waive regulations for the purpose of allowing applicants to avoid duplication of requirements and to allow the efficient implementation of the proposed projects. However, the agencies may not waive regulations pertaining to patient safety nor waive regulations if such waiver would risk patient safety. Further, any waivers approved under this authority may not exceed the life of the project or such shorter time periods as the authorizing commissioner may determine.

Accordingly, any regulatory waivers approved herein are for projects and activities as described in the Project Plan application and any implementation activities reasonably associated therewith. Such regulatory waivers may no longer apply should there be any changes in the nature of a project. It is the responsibility of the PPS and the providers that have received waivers to notify the relevant agency when they become aware of any material change in the specified project that goes beyond the scope of which the waiver was granted. Further, any regulatory waivers approved are only for the duration of the projects for which they were requested.

The approval of regulatory waivers are contingent upon the satisfaction of certain conditions. In all cases, providers must be in good standing with the relevant agency or agencies. Other conditions may be applicable as set forth in greater detail below. The failure to satisfy any such conditions may result in the withdrawal of the approval, meaning that the providers will be required to maintain compliance with the regulatory requirements at issue and could be subject to enforcement absent such compliance.

Specific requests for regulatory waivers included in the St. Barnabas Hospital (dba SBH Health System) PPS Project Plan application are addressed below.

36.01 SBH 2.a.i, 2.b.iii, 3.a.i, 3.b.i, 3.c.i 10 NYCRR §§ 702.3, 710.9, 711.2, 715-2.2, 715-2.4

Background and justification provided in your request: Sections 702.3 and 711.2 set construction standards for medical facilities in general, Sections 715-2.2 and 715-2.4 set standards for freestanding ambulatory care facilities. In addition, Section 710.9 requires a preopening survey after the completion of a construction project.

In order to fulfill the goals of Project 2.a.i to provide more primary care services to underserved areas, there will be an expansion of the capacity of primary care providers, which will likely require new construction and renovation. Likewise, Projects 2.b.iii, 3.b.i, and 3.c.i may require an investment in primary care infrastructure; some facilities may have to be renovated in order to provide more urgent care, more robust cardiovascular, and diabetes services, and it is also possible that new sites may need to be constructed. In addition, Project 3.a.i will require a reconfiguration of spaces of primary care providers in order to provide behavioral health care services at those sites, or for Article 31 or 32 sites to provide space for primary care services, and substantial construction is likely to occur at some facilities under these projects. The design of these new spaces under these projects may conflict with particular regulatory requirements for the design of clinics. Such regulatory requirements incorporate provisions of the Guidelines for the Design and Construction of Health Care Facilities, which set out detailed rules for these facilities. Having to follow all of these requirements could be particularly problematic in the context of the behavioral health integration requirement given that these standards where not written with physical and behavioral health integration in mind. Moreover, having to undergo the preopening survey process could lead to delays in the opening of the new unit, and therefore at the very least an expedited survey process is necessary.

Response to waiver request:

Construction Standards. Denied. The PPS requested waivers of §§ 711 through 715, which set forth construction standards. Due to patient safety concerns, these regulations cannot be waived. However, the Department will expedite the review of projects associated with DSRIP Project Plans to the extent possible.

Pre-Opening Surveys. Denied. The PPS requested waivers of 10 NYCRR § 701.9, pertaining to CON pre-opening surveys. These requests are denied, as pre-opening surveys are an important patient safety protection. However, the Department will expedite pre-opening surveys connected with DSRIP projects to the extent possible.

36.02 SBH ALL 10 NYCRR § 405.9(f)(7)

Background and justification provided in your request: Section 405.9(f)(7) requires hospitals to ensure that patients may not be discharged or transferred to another location based upon source of payment. This regulation could be interpreted to prohibit hospitals from transferring their patients to other providers within the same PPS, since the hospital would have a financial relationship with the other provider. For example, if one hospital in a PPS were to transfer a patient to the lead coalition provider because the lead coalition provider specializes in

treating the patient's condition, this could be viewed as a transfer based on source of payment since the lead coalition provider distributes DSRIP funds to the transferring hospital.

Response to waiver request:

Admission, Transfer and Discharge. No waiver needed. The PPS requested waivers of 10 NYCRR § 405.9(f)(7), which provide important protections related to the admission, transfer or discharge of patients from in-patient settings, including prohibiting decisions about admission, transfer or discharge based on source of payment. No regulatory waiver is needed for purposes of permitting transfers and discharges of patients between PPS partners, provided that decisions to admit, transfer or discharge are clinically based and appropriate documentation is made thereof.

36.03 SBH ALL 10 NYCRR § 600.9(c).

Background and justification provided in your request: Section 600.9(c) prohibits a medical facility from sharing gross income or net revenue with an individual or entity that has not received establishment approval. This could be interpreted as prohibiting a hospital that receives Department funds under DSRIP from distributing those funds to non-established providers who are in the same PPS. Such an interpretation would be contrary to one of the key elements of DSRIP: the distribution of funds by the lead coalition provider to other providers participating in the PPS.

Response to waiver request:

Revenue Sharing. Approved. The PPS requested a waiver of 10 NYCRR § 600.9, pertaining to revenue sharing. The waiver is approved to the extent that the regulation otherwise would prohibit providers from receiving DSRIP incentive payments distributed by the PPS Lead.

36.04 SBH 2.b.iv, 3.b.i, 3.c.i, 3.d.ii 10 NYCRR § 766.4(a), (b)

Background and justification provided in your request: Section 766.4 allows doctors, midwives, and nurse practitioners to order licensed home care services, but it does not allow physician's assistants (PAs) to order such care. As part of their efforts to keep patients out of the hospital, the DSRIP projects listed above are likely to involve orders for home care. Patients often are in need of home care services back at home after staying in a hospital (2.b.iv). Patients who receive cardiovascular care (3.b.i), or diabetes care (3.c.i) under those projects also may need home care services. Likewise, on some occasions, patients with asthma symptoms may need home care to help manage their symptoms back at home (3.d.ii). Allowing PAs to order home care as part of these projects would make it easier for these providers to order such care and thus could potentially play a role in reducing inpatient admissions.

Response to waiver request:

Determination Pending.

36.05 SBH 3.a.i 10 NYCRR §§ 401.2(b), 401.3(d)

Background and justification provided in your request: Section 401.2(b) allows the operating certificate of an Article 28 provider to be used only by the Article 28 operator at the

Article 28 provider's site of operation. The Department has interpreted this to mean that the operator must have exclusive site control and cannot share the site with another entity. Section 401.3(d) prohibits an Article 28 provider from leasing or subletting any portion of its facility unless the entity that leases the facility conforms to all of the requirements imposed on Article 28 providers. In effect, these two provisions prohibit Article 28 providers from sharing space with any provider not licensed under Article 28—including a physician group practice, a clinic licensed by OMH, or a substance abuse clinic licensed by OASAS. This would prohibit Article 28 providers from allowing other providers with expertise in mental health care or substance abuse services to provide care in their facilities, thereby limiting their options at integrating care. This interpretation would prevent residential care facilities from sharing space with primary care clinics, a possible aspect of Project 2.a.i.

Response to waiver request:

Integrated services. Approved solely with respect to14 NYCRR 599.4(r) and (ab), which will be waived contingent upon following the DSRIP Project 3.a.i Licensure Threshold Model outlined in Appendix A to this letter. The Department, OMH and OASAS have determined that no additional waivers are needed if providers are integrating services under such model. As noted in Appendix A, the use of this model is contingent upon:

- submission of an application by the PPS with the identification all providers involved in such model;
- the verification of the good standing of such providers by DOH, OMH and OASAS, as appropriate;
- satisfaction of the physical plant standards as delineated in Appendix A.

If you do not believe that this model meets your needs, or if you later identify the need for a waiver, please send us a request at DSRIP@health.ny.gov.

36.06 SBH 2.a.i, 2.b.iii, 3.a.i, 3.b.i, 3.c.i 10 NYCRR §§ 670.1, 670.2, 670.3, 709.1, 709.2, 709.3, 710.1

Background and justification provided in your request: When medical facilities seek to undertake certain projects, the certificate-of-need (CON) regulations cited require those facilities, including acute care facilities and residential care facilities, to submit applications to the Department, demonstrate a public need for their projects in the application, and obtain Department prior approval before initiating their projects.

The projects listed above are likely to require providers to undertake construction and service changes that would implicate the CON rules. In particular: a) Project 2.a.i requires a large investment in primary care capacity and some providers will need to expand operations in order to meet that enhanced capacity; b) Project 2.a.i also requires investment health information technology infrastructure, and some HIT investments enacted by providers—a group of providers that includes residential health care facilities—will fall within the scope of CON regulation; c) Projects 2.b.iii, 3.b.i, and 3.c.i will likely require the creation of new spaces to handle the increased demand for primary care, cardiovascular services, and diabetes services under DSRIP; and d) Project 3.a.i will likely require construction and renovation at Article 28 providers to create new spaces for behavioral health care, and likewise some Article 28 providers may provide services at new sites. Requiring a demonstration of public need and a separate application for these projects is unnecessary. Department approval of the DSRIP

projects and their implementation plans should be sufficient, particularly in light of the fact that the PPS has conducted a community needs assessment, and used the results of that assessment to inform its project selection. If the Department is unwilling to waive these regulations in full, the Department should at least provide a highly expedited review process to ensure that DSRIP projects are not delayed.

Response to waiver request:

Public Need and Financial Feasibility. Approved. The PPS requested waivers of 10 NYCRR §§ 670.1, 709 and 710.2, with respect to the public need and financial feasibility components of the CON process. Waivers are approved, however, that:

- No waiver is available for establishment applications.
- Only the public need and financial feasibility components of the CON process are waived, meaning that a construction application still needs to be filed through NYSE-CON and provider compliance will still be reviewed.
- No waiver is available for specialized services, CHHA service area expansions, and hospital and NH bed increases, which will be determined on a case-by-case basis.

36.07 SBH 3.a.i 14 NYCRR §§ 599.3(b), 599.4(r), (ab); 14 NYCRR §§ 800.2(a)(6), (14), 810.3, 810.3(f), (l)

Background and justification provided in your request: OMH regulations require Article 28 providers to obtain an OMH license if they provide more than 10,000 mental health visits annually, or if mental health visits comprise more than 30 percent of the provider's annual visits and the total number of visits is at least 2,000 visits annual (the OMH threshold). OASAS regulations require an Article 28 provider to obtain a certification from OASAS if it provides any substance abuse services. Under 3.a.i, Article 28 providers will increase their provision of both mental health and substance abuse services so that patients can receive physical and behavioral health services in one setting. It is highly likely that some of the providers participating in 3.a.i will cross the OMH threshold, and all Article 28 providers that provide any substance abuse services would be required to obtain OASAS certification. Requiring OMH and/or OASAS licensure would conflict with the goals of 3.a.i. Going through the certification process would be an unnecessary administrative burden and could materially slow implementation of needed new capacity to serve the attributed population. Further, having to comply with multiple licenses would force Article 28 providers to comply with new rules that would have little benefit to patients. For example, Article 28 providers are already required to maintain medical records that meet Department standards; requiring their records to also meet OMH standards would not improve patient care. Forcing providers to comply will new and unnecessary administrative processes and rules will discourage providers from providing such integrated care.

Response to waiver request:

Integrated services. Approved solely with respect to14 NYCRR 599.4(r) and (ab), which will be waived contingent upon following the DSRIP Project 3.a.i Licensure Threshold Model outlined in Appendix A to this letter. The Department, OMH and OASAS have determined that no additional waivers are needed if providers are integrating services under such model. As noted in Appendix A, the use of this model is contingent upon:

- submission of an application by the PPS with the identification all providers involved in such model;
- the verification of the good standing of such providers by DOH, OMH and OASAS, as appropriate;
- satisfaction of the physical plant standards as delineated in Appendix A.

If a PPS later identifies the need for a waiver, a request can be made at that time.

36.08 SBH 2.a.i, 2.b.iv, 3.a.i, 3.b.i, 3.c.i, 3.d.ii DOH: 10 NYCRR §§ 86-4.9(c)(8), 401.2(b); OMH: 14 NYCRR § 599.14; OASAS: 14 NYCRR § 822-3.1(b)

Background and justification provided in your request: Section 86-4.9(c)(8) prohibits freestanding ambulatory care facilities from billing for services provided off site. Section 401.2(b) allows an Article 28 to use its operating certificate only for services at its designated site of operation, which has been interpreted as prohibiting providers from providing services offsite. Sections 599.14 and 822-3.1(b) impose similar rules on mental health and substance abuse providers, respectively. Providers would benefit from the ability to provide services off site in carrying out multiple DSRIP projects.

This ability would be particularly beneficial in carrying out Project 2.a.i: allowing facilities to provide care in alternative settings would help promote an integrated delivery system and would discourage facilities from providing care in silos. Similarly, as part of the care transition project, a patient who is treated by a professional in a hospital may benefit from seeing that same professional at home (2.b.iv). Projects 3.b.i, 3.c.i and 3.d.ii aim to improve cardiovascular, diabetes and asthma care, and facility-based practitioners may seek to provide services in the home as part of that enhanced care. Social workers employed by Article 28 providers may seek to provide behavioral health services within a patient's home (3.a.i). In short, providers seek the flexibility to provide needed care in the setting that is most conducive to treatment.

Response to waiver request:

Department-Off-Site Services or Home Visits. Approved. The PPS requested waivers of 10 NYCRR § 401.2(b) for the purpose of allowing practitioners affiliated with Article 28 providers to provide services outside of the certified service site. The request is approved, contingent upon notification by the PPS of the specific providers, practitioners and services. However, reimbursement for the provision of such services would not be available absent approval of a State Plan Amendment (SPA) to the State Medicaid Plan and associated state regulations, both of which are being pursued by the Department. In addition, the Department will explore, through Value-based Payment options, incorporating more flexibility for home visits, telemedicine and team visits.

OMH- denied.14 NYCRR § 599.14. Per CMS, Medicaid will not reimburse for mental health services provided off-site.

OASAS- OASAS- Approved. The request is approved, contingent upon notification by the PPS of the specific providers, practitioners and services. However, reimbursement for the provision of such services would not be available absent approval of a State Plan Amendment (SPA) to the State Medicaid Plan being pursued by OASAS

36.09 SBH 3.a.i OMH: 14 NYCRR §§ 551.6, 551.7: OASAS: 14 NYCRR §§ 810.6, 810.7

Background and justification provided in your request: Section 551.6 requires Article 31 providers who are licensed by OMH to undergo prior approval review if they undertake certain projects, including the establishment of a new satellite location and the expansion of caseload by 25 percent or more for clinic treatment programs. Section 551.7 requires a demonstration of public need as part of this review. Similarly, Section 810.6 requires Article 32 providers who are licensed by OASAS to undergo prior approval review if the provider offers services at a new location or increases capacity of a service where capacity is identified in the provider's operating certificate, and Section 810.7 requires the applicant to demonstrate public need for its project as part of the review. Project 3.a.i is likely to fall within the reach of these regulations. As part of behavioral health integration, Article 31 and Article 32 providers are likely to provide services at new locations—more specifically, they may provide care within an Article 28 facility. While establishing a new satellite location is technically subject to E-Z PAR review, in practice this process is not easy for providers: they must obtain a letter of support from a local government unit to demonstrate there is a public need for the project, and the process can be lengthy. Requiring prior approval review for the behavioral health integration project would be duplicative of the DSRIP process itself, since the PPS will already have to submit its implementation plan to the state for review. There is no need to impose a separate prior approval review process on top of the review process embedded into DSRIP itself.

Response to waiver request:

Integrated services. Approved solely with respect to14 NYCRR 599.4(r) and (ab), which will be waived contingent upon following the DSRIP Project 3.a.i Licensure Threshold Model outlined in Appendix A to this letter. The Department, OMH and OASAS have determined that no additional waivers are needed if providers are integrating services under such model. As noted in Appendix A, the use of this model is contingent upon:

- submission of an application by the PPS with the identification all providers involved in such model;
- the verification of the good standing of such providers by DOH, OMH and OASAS, as appropriate;
- satisfaction of the physical plant standards as delineated in Appendix A.

If a PPS later identifies the need for a waiver, a request can be made at that time.

36.10 SBH 3.a.i OMH: 14 NYCRR §§ 599.5(c), 599.12(a)(6), OPWDD: 14 NYCRR § 679.99(l). OASAS: 14 NYCRR § 814.7

Background and justification provided in your request: The OMH regulations cited allow mental health providers licensed by OMH (Article 31 providers) to share program space only if they have a written space sharing plan that has been approved by OMH. As part of the behavioral health integration project, providers licensed by OMH are likely to share space with providers of physical health services as well as other behavioral health providers. The PPS's implementation plan will indicate which providers are planning to share space, and assuming the Department approves that implementation plan, the Department will approve the space sharing plans. Providers should not have to obtain a separate approval from OMH. While the OASAS regulations do not require OASAS approval of space sharing plans, they do require providers to develop such plans. Similarly, although the OPWDD regulations do not forbid Article 16 clinics from sharing space (a possible element of Project 3.a.i as providers for the developmentally disabled are also likely to participate in integration efforts), the requirement that

the facility's services are provided principally to persons with developmental disabilities could be interpreted to discourage sharing of space. The PPS therefore requests that the relevant agencies interpret these rules to provide sufficient flexibility for providers to share space.

Response to waiver request:

Integrated services. Approved solely with respect to14 NYCRR 599.4(r) and (ab), which will be waived contingent upon following the DSRIP Project 3.a.i Licensure Threshold Model outlined in Appendix A to this letter. The Department, OMH and OASAS have determined that no additional waivers are needed if providers are integrating services under such model. As noted in Appendix A, the use of this model is contingent upon:

- submission of an application by the PPS with the identification all providers involved in such model;
- the verification of the good standing of such providers by DOH, OMH and OASAS, as appropriate;
- satisfaction of the physical plant standards as delineated in Appendix A.

If a PPS later identifies the need for a waiver, a request can be made at that time.

In cases where waivers are approved, the agencies will send letters directed to the providers which otherwise would be responsible for complying with the regulatory provisions at issue. Providers further will be advised that agency staff who conduct surveillance activities will be notified that these regulatory waivers have been approved; however, they should maintain a copy of their waiver letters at any site subject to surveillance.

Please note that the Department of Health will publish on its website a list of regulatory waivers that have been approved to assist PPSs in determining whether additional waivers may be appropriate for the activities within a PPS. Additional requests for waivers, as well as any questions regarding the foregoing, may be sent by email to DSRIP@health.ny.gov with Regulatory Waiver in the subject line.

Thank you for your cooperation with this initiative. We look forward to working with you to transform New York's delivery system.

Sincerely,

Howard Zucker M.D.

Howard A. Zucker, M.D., J.D.
Acting Commissioner
New York State Department of Health

Ann Marie T. Sullivan, M.D. Commissioner
New York State Office of Mental Health

Arlene González-Sánchez
Commissioner
New York State Office of Alcoholism
And Substance Abuse Services

Attachment A
DSRIP Project 3.a.i Licensure Thresholds

Guidance for DSRIP Performing Provider Systems Integrating Primary Care and Behavioral Health (Mental Health and/or Substance Use Disorder) Services under Project 3.a.i

Background

Generally, to offer both primary care and behavioral health services (meaning mental health and/or substance use disorder services), a provider must be licensed or certified by more than one state agency (Department of Health, Office of Mental Health or Office of Alcoholism and Substance Abuse Services), unless they fall under the applicable "Licensure Threshold."

In order to facilitate integration of primary care and behavioral health services for purposes of Project 3.a.i, the Department of Health (DOH) and the Office of Mental Health (OMH) will raise their Licensure Thresholds and the Office of Alcoholism and Substance Abuse Services (OASAS) will implement a Licensure Threshold for outpatient providers licensed or certified by DOH, OMH or OASAS that are part of the DSRIP project, permitting such providers to integrate primary care and behavioral health services under a single license or certification so 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.

In order to help ensure quality care and patient safety, providers that wish to integrate services between the existing Licensure Threshold and the DSRIP Project 3.a.i Licensure Threshold will be expected to be in good standing and adhere to prescribed sections of the integrated outpatient regulations -- 10 NYCRR Part 404, 14 NYCRR Part 598 and 14 NYCRR Part 825.

A. Primary Care Provider Offering Mental Health Services

Existing Licensure Threshold

Currently, a provider licensed under PHL Article 28 and offering mental health services – meaning a general hospital outpatient department or a diagnostic and treatment center (primary care provider) – and which has more than 2,000 total visits per year must be licensed under Article 31 of the Mental Hygiene Law (MHL) by OMH if it has **more than 10,000 annual visits** for mental health services or **more than 30 percent of its total annual visits** are for mental health services.

DSRIP Project 3.a.i Licensure Threshold

OMH will raise this Licensure Threshold for DSRIP providers participating in 3.a.i projects so that primary care providers may provide **up to 49 percent of its total annual visits** for mental health services without MHL Article 31 licensure.

Prescribed Regulatory Requirements

In addition to being in compliance with applicable PHL Article 28 requirements, DSRIP providers integrating services between the existing Licensure Threshold and the DSRIP Project 3.a.i Licensure Threshold will need to meet the prescribed regulatory requirements of DOH's integrated outpatient services regulations – 10 NYCRR Part 404:

- 10 NYCRR 404.4(f), which defines "integrated care services."
- 10 NYCRR 404.6(b), which provides the governing board's oversight responsibilities with respect to the provider integrating services.
- 10 NYCRR 404.7(c)(1), (c)(2), (e) and (f), which require treatment planning for any patient receiving behavioral health services from an integrated services provider.
- 10 NYCRR 404.8(a), (b), (c), (d), (e), (f), (g), (i), (j) and (l), which identify minimum policies and procedures for integrated services providers.
- 10 NYCRR 404.9(b)(2)(i), (b)(2)(ii)(b) and (b)(2)(iii), which identify the minimum services required of providers that will be integrating mental health care services.
- 10 NYCRR 404.10(c)(1)(iv) and (c)(1)(vii), which provide general facility requirements for individual and group sessions and maintenance of records and confidentiality of all patient information.
- 10 NYCRR 404.11(a)(2)(i) and (a)(2)(ii), which require providers integrating mental health services to comply with quality assurance requirements under 14 NYCRR Part 599.
- 10 NYCRR 404.13(a), (d)(1), (d)(2)(ii) and (d)(11), which require that a record be maintained for every individual admitted to and treated by a provider integrating services and be able to accept consent forms, if applicable. Additional requirements include minimum content fields specific to each model.

B. Primary Care Provider Offering Substance Use Disorder Services

Existing Licensure Threshold

Currently, there are no Licensure Thresholds. A primary care provider may not provide substance use disorder services without being certified by OASAS pursuant to MHL Article 32.

DSRIP Project 3.a.i Licensure Threshold

OASAS will implement a Licensure Threshold for DSRIP providers participating in 3.a.i projects so that primary care providers may provide **up to 49 percent of its total annual visits** for substance use disorder services without MHL Article 32 certification.

Prescribed Regulatory Requirements

In addition to being in compliance with applicable PHL Article 28 requirements, DSRIP providers integrating substance use disorder services up to the DSRIP Project 3.a.i Licensure Threshold will need to meet the prescribed regulatory requirements of DOH's integrated outpatient services regulations – 10 NYCRR Part 404:

- 10 NYCRR 404.4(f), which defines "integrated care services."
- 10 NYCRR 404.6(b), which provides the governing board's oversight responsibilities with respect to the provider integrating services.
- 10 NYCRR 404.7(c)(1), (c)(2), (e) and (f), which require treatment planning for any patient receiving behavioral health services from an integrated services provider.
- 10 NYCRR 404.8(a), (b), (c), (d), (e), (f), (g), (i), (j) and (l) which identify minimum policies and procedures for integrated services providers.
- 10 NYCRR 404.9(c)(4), which identifies the minimum services required of providers that will be integrating substance use disorder services.
- 10 NYCRR 404.10(c)(1)(iv) and (c)(1)(vii), which provide general facility requirements for individual and group sessions and maintenance of records and confidentiality of all patient information.
- 10 NYCRR 404.11(a)(2)(i) and (a)(2)(ii), which require providers integrating substance use disorder services to comply with quality assurance requirements under 14 NYCRR Part 822.
- 10 NYCRR 404.12(c)(2), which provides staffing requirements for providers offering substance use disorder services.
- 10 NYCRR 404.13(a), (d)(1), (d)(2)(iii), (d)(11) and (f)(2), which require that a record be maintained for every individual admitted to and treated by a provider integrating services and be able to accept consent forms, if applicable. Additional requirements include minimum content fields specific to each model.

C. Behavioral Health Services Provider Offering Primary Care Services

Existing Licensure Threshold

Currently, a provider licensed by OMH under MHL Article 31 to provide outpatient mental health services or certified by OASAS under MHL Article 32 to provide outpatient substance use disorder services must obtain PHL Article 28 licensure by DOH if **more than 5 percent of total annual visits** are for primary care services or if any visits are for dental services.

DSRIP Project 3.a.i Licensure Threshold

DOH will raise this Licensure Threshold for DSRIP providers participating in 3.a.i projects so that a behavioral health services provider may provide **up to 49 percent of its total annual visits** for primary care services without PHL Article 28 licensure.

Prescribed Regulatory Requirements

In addition to being in compliance with applicable MHL Article 31 or 32 requirements, DSRIP providers integrating services between the existing Licensure Threshold and the DSRIP Project 3.a.i Licensure Threshold will need to meet the prescribed regulatory requirements of OMH or OASAS' integrated outpatient services regulations – 14 NYCRR Part 598 or 14 NYCRR Part 825, respectively:

- 14 NYCRR 598.4(f) and (j) or 14 NYCRR 825.4(f) and (j), which define "integrated care services" and "primary care services."
- 14 NYCRR 598.6(b) or 14 NYCRR 825.6(b), which provides the governing board's oversight responsibilities with respect to the integrated services provider.
- 14 NYCRR 598.8 (c), (d), (e), (g), (i), (j), (k), (l), (m), (n) and (o) or 14 NYCRR 825.8(c), (d), (e), (g), (i), (j), (k), (l), (m), (n) and (o), which identify minimum policies and procedures for integrated services providers.
- 14 NYCRR 598.9(a) or 14 NYCRR 825.9(a), which identifies the minimum services required of providers that will be integrating primary care services.
- 14 NYCRR 598.10 or 14 NYCRR 825.10, which provides minimum physical plant requirements for facilities integrating services.
- 14 NYCRR 598.11(a)(1) or 14 NYCRR 825.11(a)(1), which requires providers integrating primary care services to ensure the development and implementation of a written quality assurance program.
- 14 NYCRR 598.12(a), (b) and (c)(1) or 14 NYCRR 825.12(a), (b) and (c)(1), which provide staffing requirements.
- 14 NYCRR 598.13(a), (c), (d)(1), (d)(2)(i), (d)(10), (d)(11), (e) and (f) or 14 NYCRR 825.13(a), (c), (d)(1), (d)(2)(i), (d)(10), (d)(11), (e) and (f), which require that a record be maintained for every individual admitted to and treated by a provider integrating services. Additional requirements include designated record keeping staff, record retention and minimum content fields specific to each model. Confidentiality of records is assured via patient consents and disclosures compliant with state and federal law.

D. Mental Health Services Provider Offering Substance Use Disorder Services and Substance Use Disorder Services Provider Offering Mental Health Services

Existing Licensure Threshold

Currently, there are no Licensure Thresholds. However, programs licensed by OMH or certified by OASAS currently are able to integrate mental health and substance use disorder services with certain limitations pursuant to a Memorandum of Agreement between the agencies.

DSRIP Project 3.a.i Licensure Threshold

OMH licensed and OASAS certified providers may continue to integrate mental health and substance use disorder services **up to 49 percent of their total annual visits.**

Prescribed Regulatory Requirements

DSRIP providers integrating mental health and substance use disorder services will need to be in compliance with applicable MHL Article 31 or 32 requirements. In addition, such providers will need to meet the prescribed regulatory requirements of OMH or OASAS' integrated outpatient services regulations – 14 NYCRR Part 598 and 14 NYCRR Part 825, respectively:

- 14 NYCRR 598.4(f) or 14 NYCRR 825.4(f), which defines "integrated care services."
- 14 NYCRR 598.6(b) or 14 NYCRR 825.6(b), which provides the governing board's oversight responsibilities with respect to the integrated services provider.
- 14 NYCRR 598.8(c), (d), (e), (g) and (i) or 14 NYCRR 825.8(c), (d), (e), (g) and (i), which identify minimum policies and procedures for integrated services providers.
- 14 NYCRR 598.9(c) or 14 NYCRR 825.9(b), which identifies the minimum services required of providers that will be integrating mental health or substance use disorder services.
- 14 NYCRR 598.12(c)(2), which provides staffing requirements for OMH licensed providers integrating substance used disorder services.
- 14 NYCRR 598.13(a), (d)(1), (d)(2)(iii) and (d)(11) or 14 NYCRR 825.13(a), (d)(1), (d)(2)(ii) and (d)(11), which require that a record be maintained for every individual admitted to and treated by a provider integrating services and be able to accept consent forms, if applicable. Additional requirements include minimum content fields specific to each model.

Above DSRIP Project 3.a.i Licensure Thresholds

When a provider believes its volume of services will approach the DSRIP Project 3.a.i Licensure Threshold limits outlined above, a provider has the option of integrating services by either seeking a second license for a particular site or integrating services under the integrated outpatient services regulations (see 10 NYCRR Part 404, 14 NYCRR Part 598 and 14 NYCRR Part 825). Providers that elect to integrate services under the integrated outpatient regulations will need to comply with all applicable provisions.

Providers may not bill Medicaid for any service rendered above the DSRIP Project 3.a.i Licensure Threshold amount unless the appropriate licensure or certification is in place at the time the service was rendered.

Requirements

Providers that are interested in integrating services under a single license will need to submit an application to the Department of Health, which will be available soon, so that DOH, OMH and OASAS will, among other things, be able to:

- identify the outpatient provider and its sites that will be integrating services under the Licensure Thresholds;
- ascertain the services to be added;
- project the annual visits for the services that will be integrated at a provider site;
- verify that the provider integrating services is in good standing. A provider is in good standing if each clinic site:
    - is licensed by OMH and has been operating for a period of 1 year or greater as documented on the operating certificate (Tier 3 providers are not in good standing for purposes of these requirements); and/or
    - is certified by OASAS and all of its programs have an operating certificate with partial or substantial compliance (2 or 3 years); and/or
    - has an operating certificate from DOH and is not currently under any enforcement action or pending enforcement;
- if applicable, review floor plans and other physical plant issues.

Billing Guidance

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., behavioral health services and primary care services). Provider clinic payment will be processed through the APG grouper/pricer and paid in accordance with the payment blend and APG pricing rules (packaging, discounting, bundling) associated with services normally billed under that APG rate code. Providers are expected to adhere to the licensure threshold limits identified in the table below. Providers may use a modifier to indicate when a separate and distinct procedure is performed (e.g., Procedure Modifier 59) in accordance with the American Medical Association's approved coding/billing guidelines for the procedures/services coded supported by appropriate documentation that justifies the modifier selected. Federally Qualified Health Centers that have not opted into APGs should bill their all-inclusive PPS rate of all services furnished to a patient on the same day.

LICENSURE THRESHOLDS

Existing Licensure Thresholds	DSRIP Project 3.a.i Licensure Thresholds
A PHL Article 28 provider that has more than 2,000 total visits per year must be licensed by OMH if it has more than 10,000 annual visits for mental health services or more than 30 percent of its total annual visits are for mental health services.	A PHL Article 28 provider that has more than 2,000 total visits per year must be licensed by OMH if more than 49 percent of its total annual visits are for mental health services.
No existing Licensure Threshold. A PHL Article 28 provider may not provide substance use disorder services without being certified by OASAS pursuant to MHL Article 32.	A PHL Article 28 provider must be certified by OASAS if more than 49 percent of its total annual visits are for substance use disorder services.
A MHL Article 31 provider or MHL Article 32 must be licensed by DOH if more than 5 percent of its total annual visits are for primary care services or if any visits are for dental services.	A MHL Article 31 provider or MHL Article 32 must be licensed by DOH if more than 49 percent of its total annual visits are for primary care services or if any visits are for dental services.
No existing Licensure Threshold. A MHL Article 31 provider or MHL Article 32 is able to integrate mental health and substance use disorder services pursuant to a Memorandum of Agreement between OMH and OASAS.	A MHL Article 31 provider must be certified by OASAS if more than 49 percent of its total annual visits are for substance use disorder services. A MHL Article 32 provider must be certified by OMH if more that 49 percent of its total annual visits are for mental health services.