



Department
of Health

Office of
Mental Health

Office of Alcoholism and
Substance Abuse Services

Integrated Outpatient Services – Implementation Guidance

Effective January 1, 2015, New York State established the licensure category “Integrated Outpatient Services”, appearing identically within regulation for Office of Mental Health licensed providers (14 NYCRR Part 598), Office of Alcoholism and Substance Abuse Services licensed providers (14 NYCRR Part 825), and Department of Health licensed providers (10 NYCRR Part 404).

This document is intended to provide interpretive/implementation guidance with respect to certain provisions of the Integrated Outpatient Services regulations – it is not intended to address each provision of the Integrated Outpatient Services regulations. While the headings align with the headings of the respective regulatory Parts, this guidance document addresses only selected portions of the regulations where clarity and/or guidance may be of benefit to providers seeking to integrate physical and/or behavioral health services under the new regulations.

Background and Intent

This section speaks to the background and intent of the Integrated Outpatient Services regulations – 10 NYCRR Part 404, 14 NYCRR Part 598 and 14 NYCRR Part 825 – as applicable to the Department of Health (DOH), Office of Mental Health (OMH), and Office of Alcoholism and Substance Abuse Services (OASAS). These regulations are based on recognition that behavioral (i.e., mental illness and/or substance use disorders) and physical health conditions are not distinct conditions and often occur at the same time. The regulations intend to promote increased access to physical and behavioral health services at a single site, to foster the delivery of integrated services and to establish standards for these integrated services in certain outpatient settings.

► Philosophy

The organization and its outpatient clinic program should be committed to a clearly articulated philosophy consistent with “integrated treatment”, i.e., appropriately combining physical and behavioral health interventions in a single setting that welcomes individuals with co-occurring disorders and involves them in empathic, coordinated, and continuous treatment relationships. This can best be achieved via review of written materials, such as brochures, and interviews with senior staff, program director(s), practitioners, and those receiving integrated services and/or their families for a clear understanding of the philosophy and areas of discrepancy.

► **Use of Terminology**

These regulations are intended to facilitate one model of delivering integrated care services. There is no prohibition on other models that exist or may exist so long as they are otherwise allowable. 14 NYCRR 825.6(a), 14 NYCRR 598.6(a) and 10 NYCRR 404.6(a) state that “[a] provider may promote itself as an integrated services provider if the provider has been properly certified by an appropriate state licensing agency”.

► **Communication**

The three State agencies will work collectively to assist providers in the implementation of integrated care services. The “host” agency will be the primary point of contact for applications, reviews, inspections and questions.

Legal Base

This section provides the Legal Base applicable to all three agencies for the promulgation of these Regulations.

Applicability

This section identifies providers of outpatient services or programs to which the standards outlined in the regulations would apply should they elect to provide integrated care (e.g., providers certified or licensed, or in the process of pursuing licensure or certification, by at least two of the participating state agencies). Such providers would continue to maintain regulatory standards applicable to the host site’s license or certification. 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.

► **Applicability**

These regulations are not intended to be duplicative or create inconsistency between the integrated outpatient services regulation and existing regulations for clinics, diagnostic and treatment centers or general hospital outpatient programs. Rather, they provide the basis for integrated service providers operating pursuant to the standards of the state agency that initially licensed or certified the provider at the site at which services will be added.

► **Multiple Licenses**

The requirement that providers be licensed or certified by more than one agency is intended to allow the respective state agencies to expedite approval and streamline oversight at the site where additional services are to be added. The multiple license requirement means that the provider must possess a license or certification from DOH, OMH and/or OASAS for the clinic site seeking to integrate services, and be licensed or certified within the organization for the services the provider now wishes to add to that particular clinic site.

▶ **“Good Standing”**

In order to expedite approval of the addition of services at a site, the provider needs to be in good standing according to the standards of each agency by which it is licensed or certified. The “good standing” status is necessary to be considered for approval to offer integrated services. To be in “good standing”, the provider must currently be in compliance with the regulatory standards of each agency by which it is licensed or certified, and not currently under any enforcement actions.

▶ **Health Home Affiliation**

The enabling legislation authorizing these regulations derives from the Health Home statute (NYS Social Services Law Section 365-l); therefore, Health Home affiliation is required. The objective of the integrated services initiative is consistent with the objective of the Health Homes program. Membership in a DSRIP PPS alone is not sufficient.

Definitions

This section provides definitions as used in the regulations, which would be applicable to any program offering integrated outpatient services. Definitions specific to a host site’s licensing agency are found in regulations of that agency.

▶ **Integrated Service Provider**

The section defines an “integrated services provider” as a provider holding multiple operating certificates or licenses to provide outpatient services, which has also been authorized by a Commissioner of a state licensing agency to deliver identified integrated care services at a specific site in accordance with the provisions of the regulations.

▶ **Behavioral Health Care**

“Behavioral health care” means care and treatment of mental illness and/or substance use disorders.

▶ **Primary Care**

The regulations were designed to allow providers to add primary care services in certain settings where behavioral health care services are offered. “Primary care services” are 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.

▶ **Host Site**

As noted above, a “host site” is defined as a single outpatient site at which a provider which is licensed or certified by DOH, OMH or OASAS is approved to integrate services as prescribed under the regulations.

Integrated Care Models

This section describes three (3) models for host programs: (a) Primary Care Host Model with compliance monitoring by DOH; (b) Mental Health Behavioral Care Host Model with compliance monitoring by OMH; and (c) Substance Use Disorder Behavioral Care Host Model with compliance monitoring by OASAS.

Organization and Administration

This section requires any integrated services provider to be certified by the appropriate state agency and to revise any practices, policies and procedures as necessary to ensure regulatory compliance.

► Boards

Providers will need to ensure that they are capable of carrying out the requirements that “the established governing bodies of licensed integrated service shall be legally responsible for quality of care and compliance with all applicable laws and regulations.” 14 NYCRR 825.6(b), 14 NYCRR 598.6(b) and 10 NYCRR 404.6(b).

Treatment Planning

This section pertains to treatment planning for any patient receiving behavioral health services (OMH and/or OASAS) from an integrated outpatient services provider.

► Treatment Plans

Treatment plans must include physical health, behavioral health and social service needs. All diagnoses for which a patient is being treated should be included in the plan with specific treatment goals to address each area of identified patient diagnoses.

When non-medical staff (e.g., social workers) write treatment plans, they are expected to conduct a screen (not evaluation) of physical health status and include appropriately assessed areas of needs into the treatment planning goals.

Treatment planning should be person-centered and highlight the areas of needs identified by the patient. All screenings, assessments and/or evaluations results should be shared with the patient, and the patient should be allowed to identify which needs have the largest impact on his/her functioning and determine the order in which the identified needs will be addressed.

In a Behavioral Care Host Model clinic, treatment plans must be completed within 30 days of admission. In a Primary Care Host model clinic, treatment planning for behavioral health services need not begin until a patient is ready to move beyond assessment and other pre-admission services. In such DOH hosts, treatment plans must be completed no later than 30 days after the decision to begin any post-admission mental health and/or substance use disorder services, and include the mental health and/or substance use disorder diagnosis(es) and associated symptoms requiring such treatment.

These regulations require that periodic reviews of treatment plans include “an evaluation of physical health status.” By definition, such review should include any necessary adjustments to the plan including those required to address ongoing physical health needs.

The factors identified are critical to ensuring a patient’s behavioral health needs are appropriately assessed and identified and that an acceptable plan of care is developed. These are the minimum factors to be considered and providers may choose to expand on them.

► **Admission**

The expectation is that the admission diagnosis for a Mental Health Behavioral Care Host Model clinic will continue to be “mental illness” and, for a Substance Use Disorder Behavioral Care Host Model clinic, the admission diagnosis shall be “substance use disorder”.

► **Signatures**

Only **ONE** signature of a qualified health professional (or other licensed individual involved in the patient’s care) needs to sign the treatment plan. A “qualified health professional” (QHP) means an individual:

- who is in good standing with the appropriate licensing or certifying authority, as applicable;
- practicing within the scope of, and in accordance with, the terms and conditions of such licenses and certifications; and
- with a minimum of one year of experience and/or training in the treatment of behavioral health issues.

► **Managed Care Plans**

These regulations were designed to allow providers to comply with the requirements of Medicaid managed care plans. The provisions within 14 NYCRR 825.7(c)(2), 14 NYCRR 598.7(c)(2) and 10 NYCRR 404.7(c)(2) are intended to avoid any potential conflict between the treatment planning requirements of these regulations and those of Medicaid managed care companies.

► **Discharge Planning**

It is recognized that diagnostic and treatment centers and general hospital outpatient programs do not have an “admission” process nor “discharge” criteria. However, planning

for “discharge” from behavioral health treatment is a critical part of the treatment planning process.

It is the expectation that, under these regulations, “add-on” service delivery may continue when the individual’s primary reason for being admitted to the host clinic may no longer be necessary. Multidisciplinary team approach, regular team case conferencing and other collaborative approaches should be utilized within an integrated setting to ensure consistent coordinated patient care among the various services and providers. As such, planning surrounding the focus of services and transition of services (i.e., “admission and discharge” from a particular service) should be discussed and appear seamless to the patient while utilizing an integrated treatment plan.

10 NYCRR 404.7(g)(2), 14 NYCRR 598.7(g)(2) and 14 NYCRR 825.7(g)(2) all speak to “initiation of discharge planning, as appropriate.” This refers to when such “add-on” behavioral health service may no longer be necessary per the treatment plan developed. At such time, the integrated services provider must assure the person is transitioned from such service appropriately.

In addition, specific regulatory processes regarding “admission and discharge” diagnosis and coding should be followed for the particular service being provided. Historically, if a patient transfers care from substance use disorder to mental health treatment, the diagnosis typically “switches” to address the treatment focus. With a single rate code, providers have been required to match the primary diagnosis with the mental health or substance use disorder designated program. With the onset of behavioral health managed care, funding will no longer be rate code-based. Therefore, as long as substance use disorder reporting remains accurate, this should no longer be a problem – if a person diagnosed with a substance use disorder “switches” to a mental health-only diagnosis, then they will need to be “discharged” from the OASAS services package and “admitted” anew to the mental health services package which both may be rendered in the same clinic location. OASAS is in the middle of changing their CDS system to better facilitate.

Policies and Procedures

This section identifies minimum required policies and procedures for any integrated service provider.

► Description of Services Provided

An integrated service provider shall have written policies, procedures, and methods governing the provision of services to patients, including a description of each service provided. The regulations outline the minimum content that should be addressed. Providers that are adding primary care services should be aware that policies and procedures for investigating, controlling and preventing infections must be developed and utilized. See 14 NYCRR 598.8(m) and 14 NYCRR 825.8(m) for specific requirements.

Integrated Care Services

This section identifies the minimum services required of any integrated services provider providing any of the three care models. The section also identifies services for each model which may be provided at an integrated services provider's option.

► Screening/Assessment

The term "initial assessment" means face-to-face interaction between a clinician and recipient and/or collaterals to determine the appropriateness of the recipient for admission to a clinic, the appropriate mental health or substance use disorder diagnosis, and the development of a treatment plan for such recipient.

Article 28 integrated services clinics should strongly consider the use of such standardized screening instruments and assessment domains, when integrating such services pursuant to these regulations. Tools available to help assess the severity of patients' symptoms of depression and anxiety in mental health integration projects have included the nine-item Patient Health Questionnaire (PHQ-9) and the seven-item Generalized Anxiety Disorder (GAD-7). These and other helpful clinical rating scales can be found here:

http://www.omh.ny.gov/omhweb/psyckes_medicaid/resources/clinician/tools/rating_scales.html

► Crisis Intervention

Crisis intervention refers to activities, including medication and verbal therapy, which are designed to address acute distress and associated behaviors when the individual's condition requires immediate attention. A crisis is an unplanned event that requires a rapid response. As such, crisis covered services need not be anticipated in a treatment plan.

Not every clinic is expected to have, or become, a community-wide mobile crisis team. However, all clinics will need to provide 24 hours a day/7 days per week availability of crisis services for its clients. Every clinic must have a plan for providing crisis services and after-hours coverage, which must be approved by the Local Governmental Unit. In the case of county providers, this plan must be approved by OMH.

The clinic plan must demonstrate the ability to accommodate crisis intakes and walk-ins during normal business hours. The after-hours crisis response plan, for clinics and satellites, must allow recipients and their collaterals that need assistance to be able to contact a licensed professional. The primary clinician must be contacted the next business day with information from the licensed professional who provided the after-hours services. Additionally, the clinic must ensure that the after-hours contact procedure is explained to all recipients and their collaterals, where appropriate, during the intake process.

After-hours services may be provided in person or by phone. They may be provided directly by the clinic or pursuant to a Clinical Services Contract. The contracting option allows clinics to pool resources in ways that may make more sense in their community, depending on the community's circumstances. If this mechanism is pursued, the contract must include a

process for transmitting information about an after-hours call to the appropriate clinic by the next business day.

▶ **Psychotropic Medication Treatment**

Psychotropic medication treatment means monitoring and evaluating target symptom response, ordering and reviewing diagnostic studies, writing prescriptions and consumer education as appropriate. This service must be provided by a psychiatrist or psychiatric nurse practitioner.

▶ **Psychotherapy Services/Individual Counselling**

“Psychotherapy” (including family/collateral or groups) means therapeutic communication and interaction for the purpose of alleviating symptoms or dysfunction associated with an individual’s diagnosed mental illness or emotional disturbance, reversing or changing maladaptive patterns of behavior, encouraging personal growth and development, and supporting the individual’s capacity to achieve age-appropriate developmental milestones.

Psychotherapy should promote community integration, and may encompass interventions to facilitate readiness for and engagement of the client and family in wellness self-management, school, and employment training services, which are provided by specialized programs and service providers.

Psychotherapy may also result in the identification of a need for Complex Care Management.

▶ **Complex Care Management**

In an OMH setting, complex care management is an ancillary service to psychotherapy or crisis intervention services. It is provided by a clinician in person or by telephone, with or without the client. It is a clinical level service which is required as a follow up to psychotherapy or crisis service for the purpose of preventing a change in community status or as a response to complex conditions. Complex care management is not a stand-alone service; it is a non-routine professional service designed to coordinate care, provided subsequent to a psychotherapy or crisis visit. It is designed to address immediate mental health issues or factors that are impacting on the individual’s health or community status.

Complex care management does not include required and routine paperwork or required and routine follow up. The need for complex care management and the persons contacted must be documented in the progress note.

While complex care management must be provided by a therapist or licensed medical professional, it is not necessary that the same therapist or licensed medical professional who delivered the therapy or crisis service provide the complex care management. However, if complex care management is performed by a different therapist, the activities must be coordinated with the treating therapist and documented in the client’s progress note.

In an OASAS setting, complex care is an ancillary service, provided to or on behalf of a current patient when a critical event occurs or the patient condition requires significant coordination with other service providers.

Documentation must note the critical event or condition and the need for coordination and summarize the purpose of the coordination. Complex Care is distinguished from routine case coordination activities and must meet each of the following:

- The care coordination must occur within 5 working days of another treatment service (i.e. individual or group session).
- There must be a documented critical event or patient condition requiring coordination.
- Coordination must require a minimum 45 minutes of clinician time, although this time does not have to be contiguous; it must be on the same visit date.

► **Counseling**

Consistent with and determined by the client's stage of change/treatment, counseling for those receiving integrated behavioral health services is largely based on motivational interviewing, cognitive-behavioral counseling, or some combination of both. Motivational interviewing involves helping a client identify his or her own goals and to recognize, through a systematic examination of the individual's ambivalence, that not managing one's illnesses interferes with attaining those goals. Clients in the action or relapse prevention stage receive cognitive-behavioral counseling that includes teaching how to manage cues to use and consequences of use, teaching relapse prevention strategies, teaching drug and alcohol refusal skills, problem solving skills training to avoid high risk situations, challenging client's beliefs about substance use, and coping skills and social skills training to deal with symptoms or negative mood states.

Group counseling for substance use disorder treatment is limited to 15 people, consistent with current OASAS requirements and best practices in substance use disorder treatment.

► **Peer Support Services**

Peer Support Services are face- to- face service provided by a peer advocate to an active patient for the purpose of connecting patients to community based recovery supports consistent with a patient's treatment plan.

► **Telemedicine**

14 NYCRR 828.9(c)(3), 14 NYCRR 598.9(c)(3) and 10 NYCRR 404.9(c)(3) state "Integrated services providers of substance use disorder services shall offer, at a minimum, each of the following services ..." The regulations do not prohibit the use of telemedicine or telepsychiatry to the extent otherwise permitted by applicable regulations.

OMH has recently amended 14 NYCRR Part 599 (Clinic Treatment Services) to include a new section 599.17, which permits providers to obtain approval to provide telepsychiatry services. For the purpose of 14 NYCRR 599.17, "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. Section 599.17 prescribes that, when authorized by OMH, telepsychiatry services can 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.

► **OB/GYN and Prenatal Care Services**

For behavioral health care models, primary care services provided within the specialty of OB/GYN must be limited to routine gynecologic care and family planning provided pursuant to 10 NYCRR Part 753. Other OB/GYN services are considered specialty care and are beyond the scope of what should be offered in behavioral health care settings.

DOH will authorize the provision of prenatal care by a qualified integrated outpatient services provider approved to add primary care services, if such provider demonstrates to DOH's satisfaction that, at a minimum:

- Appropriate practitioners will be available (i.e., appropriate license/credential, training, competencies, etc. and working within the appropriate scope of practice);
- Services will apply only to uncomplicated pregnancies;
- Protocols are in place for making appropriate referrals;
- The physical facility is sufficient for the type of care (i.e., the necessary equipment);
- The provider meets Medicaid prenatal care standards, which are required for billing prenatal care services (Medicaid prenatal care standards can be found at http://www.health.ny.gov/health_care/medicaid/standards/prenatal_care/);
- The clinic agrees to participate in DOH's measurement/improvement program.

► **Referrals from Other Licensed Programs**

An Article 31 integrated services clinic can refer a person to a PROS program that it operates. When enrolled, the individual must then receive his or her services from the PROS clinic component, not the integrated services clinic.

Environment

This section outlines minimum physical plant requirements necessary for certifying existing facilities which want to provide integrated care services. The section requires programs seeking certification after January 1, 2015 or who anticipate new construction or significant renovations to comply with requirements of 10 NYCRR Parts 710 (Approval of Medical Facility Construction), 711 (General Standards of Construction) and 715 (Standards of Construction for Freestanding Ambulatory Care Facilities).

► **Separation**

Under the regulations (14 NYCRR 825.10(c)(1)(i), 14 NYCRR 598.10(c)(1)(i) and 10 NYCRR 404.10(c)(1)(i)), examination rooms must be generally available during the hours when primary care services are offered. Such rooms can be used for behavioral health

services if not being used for primary care services at that time and if appropriate for the services.

▶ **DOH Standards**

The regulations accommodate providers adding primary care services in existing space. Providers with three or fewer examination rooms need to follow only the environmental/physical plant standards as set forth in the integrated outpatient services regulations.

Prospective providers that have never obtained a license or certification from any of the three agencies prior to January 1, 2015 and therefore are not using any licensed or certified space will be required to follow existing Article 28 standards in the provision of primary care.

The additional requirements under the existing Article 28 standards for the provision of primary care services are necessary in settings with over 3 examination rooms to ensure patient health and safety in light of the higher volume of primary care visits.

The regulations are based on the 2000 edition of the Life Safety Code and include categorical waivers that have been issued by CMS based on the 2012 Life Safety Code.

▶ **Exam Rooms**

The square footages in the regulations are nationally accepted minimums. Anything smaller would compromise the provider's capability to perform proper examinations and/or provide proper treatment.

▶ **Waiting Areas**

With respect to a waiting area for pediatrics, there should be an area separated from the adult waiting space, with age appropriate furniture and materials (décor, reading material and toys). The area should be observable to reception staff.

▶ **"Clean Storage"**

It is acknowledged that creating a separate storage room/closet may not be realistic for a small clinic with limited primary care services. Refer to the applicable sections of the regulations for requirements for facilities with less than three exam rooms. The need for a separate space depends upon how much soiled material is being generated by the clinic.

▶ **Hand-Washing Station**

With respect to hand-washing station accessibility in toilet rooms, national FGI standards require that a toilet room needs to be nearby. By definition, within a "small clinic", the toilet room would be nearby to everything within that clinic.

▶ **Combustible Decorations**

With respect to "combustible decorations", these particular standards were developed and promoted in 2012 NFPA (i.e., Life Safety Code).

Quality Assurance, Utilization Review and Incident Reporting

This section outlines the requirements and obligations of an integrated services provider relative to QA/UR and Incident Reporting and are detailed by the type of model as the host program.

► Quality Assurance

The quality assurance (QA) requirements contained in 14 NYCRR 825.11(a)(1), 14 NYCRR 598.11(a)(1) and 10 NYCRR 404(a)(1) apply only to behavioral health providers adding primary care services. They are not additional requirements for Article 28 providers adding behavioral health services.

Periodic reviews are required as part of a provider's QA program, which must be designed to verify that providers have processes in place for management and support of high quality and appropriate care. The quality assurance, utilization review and incident reporting sections were designed to promote flexibility for participating providers.

Staffing

This section outlines staffing requirements by type of model as the host program and identifies specific requirements which may be unique to the primary care host model such as subspecialty credentials of a medical director.

► General

Provider must ensure that they have the staff and equipment necessary to provide services that are consistent with prevailing standards of care.

► Medical Director

The regulations require providers adding primary care or substance use disorder services to utilize a medical director. Providers adding mental health services do not have a similar requirement; however, such providers will already have a medical director in place due to their existing licensure or certification by DOH or OASAS.

For purposes of 10 NYCRR 404.12(c)(1), the medical director may be an employee or be contracted by the facility. The medical director may provide services on a full- or part-time basis. The medical director must, however, have sufficient training, experience, and administrative ability to effectively carry out his or her responsibilities. These include supervision of the QA program and reporting to the governing body. The medical director is also responsible for development and recommending policies and procedures related to patient care, medical staff and clinical privileges.

▶ CASACs

Currently CASACs are not considered qualified health professionals in OMH and DOH clinics. CASAC's are qualified health professionals in OASAS clinics. CASACs can be used for delivery of substance use disorder services in any approved integrated setting that has authority from OASAS to deliver substance use disorder services, provided that all other applicable staffing requirements are met. This does not exclude the minimum staffing requirements of other clinical professionals that work with the SUD population and OASAS providers.

Recordkeeping

This section requires that a record be maintained for every individual admitted to and treated by an integrated services provider. Additional requirements include designated recordkeeping 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.

▶ Electronic Medical Record

The regulations do not prohibit electronic medical records and information sharing. The manner of recordkeeping is left up to the provider.

In general, three different "silos" of regulations may apply to mental health clinical information (generated by OMH providers) and alcohol/substance abuse treatment information (created or maintained by OASAS providers). OMH providers are governed by State law (Mental Hygiene Law Section 33.13), and those that are covered entities are governed by HIPAA (45 CFR Parts 160 and 164). These two sets of authority (state and federal) must be read and applied together.

In contrast, there is no State law that governs the confidentiality of OASAS provider treatment records. These records are governed by federal regulations (42 CFR Part 2) and, for those providers that also are covered entities, HIPAA. Again, the two sets of federal authority must be read and applied together.

When examining disclosures among and between providers for treatment purposes, NYS Mental Hygiene Law Section 33.13 would allow these disclosures without patient consent if the other provider has a "nexus" with OMH through licensure, funding, or an agreement with OMH. This generally means OMH providers can share with other OMH providers without patient consent for care coordination purposes. With respect to disclosures for treatment purposes, OMH providers must do so in accordance with NYS Mental Hygiene Law, which is "more stringent" than HIPAA in this respect.

For OASAS providers, if they are covered entities under HIPAA, HIPAA would allow them to share information with other providers (of any type) for treatment purposes. However, 42 CFR Part 2 requires consent to share information with other providers for treatment purposes. Therefore, the tenets of 42 CFR Part 2 remain intact when making disclosures of information, for all OASAS providers, whether or not they are also covered by HIPAA. In that respect, consent to disclose information for treatment purposes is generally needed.

Generally, OASAS providers need to obtain patient consent to disclose information to another provider for any purpose (with some exceptions provided in case of medical emergencies, court orders, etc.).

▶ **Integrated Record**

The regulations reflect the importance of integrated patient records. The regulations do not prohibit the use of patient consent for purpose of providing integrated care services. The agencies are developing a guidance document which will provide additional instruction on recordkeeping and consent issues.

Application and Approval

This section outlines the process whereby a provider seeking to become an integrated services provider may submit an application for review and approval. Applications are standardized for use by all three licensing agencies but shall be reviewed by both the agency that regulates the services to be added and the agency with authority for the host clinic.

▶ **Clinic Sites**

Approval to provide “integrated services” 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.

▶ **Application Submission**

The agencies have developed a web based single application that will be transmitted to all three agencies simultaneously. Providers will be contacted by the involved agencies and may be asked for additional information as necessary. The state agency that licenses the host clinic will advise the provider of the ultimate determination. No CON application is needed for providers wanting to add primary care.

Inspection

This section requires the state licensing agency with authority to monitor the host site to have ongoing inspection responsibility pursuant to standards outlined in the respective regulations. The state licensing agency who would otherwise have licensed the services that are being added will not duplicate inspections for license renewal or compliance but will be consulted about any deficiencies relative to the added services. The section identifies specific areas of review and requires one unannounced inspection prior to renewal of an Operating Certificate or License.

► Inspections

A key benefit to the integrated outpatient services regulations is that clinics providing services governed by multiple state agencies will only be subject to an inspection by one state agency, rather than an inspection by each agency. The agencies are mindful of staff time and resources; however to ensure compliance and continued authorization for the delivery of integrated services routine inspections are necessary.

Unannounced inspections will follow the existing re-certification processes of the state agency that licensed or certified the host site, and will occur after approval.

Billing

This additional guidance pertains to billing for sites approved under the Integrated Outpatient Services regulations.

► Billing

These regulations do not effectuate any change for reimbursement of outpatient services. Integrated services providers, including FQHCs that have opted into APGs, can bill using the APG Medicaid reimbursement methodology which provides a flexible, upgradeable platform that includes payment logic to facilitate the billing of multiple behavioral/physical health procedures rendered within a single visit.

Generally, integrated services providers, including FQHCs, will be encouraged to submit a single APG claim for each visit (including those comprising multiple service types) with all the procedures/services rendered on that date of service using the host's assigned Integrated Services rate codes.

Approved integrated service clinics dependent on the licenses they hold may bill for primary care, mental health and/or substance use disorder procedures/services. All visits (Medicaid managed care or fee for service) rendered by an approved integrated service clinic should be billed using one of the Integrated Service rate codes below:

1480 - OMH APG - ARTICLE 31 INTEGRATED SERVICES
1483 - OMH APG - ARTICLE 31 INTEGRATED SERVICES (SED)
1486 - OASAS - FREE-STANDING ARTICLE 32 CLINIC INTEGR SVCS
1594 - DOH OPD APG - INTEGRATED SERVICE
1597 - DOH DTC APG - INTEGRATED SERVICE
1122 - OMH APG - ARTICLE 31 INTEGRATED SERVICES
1124 - OMH APG - ARTICLE 31 INTEGRATED SERVICES (SED)
1130 - OASAS - FREE-STANDING MMTP
1132 - OASAS - HOSPITAL ARTICLE 32 CLINIC INTEGRATED SERVICES
1134 - OASAS - HOSPITAL MMTP INTEGRATED SERVICES

Single service type visits (primary care, mental health or substance use disorder) should be billed to the payer type indicated (i.e., Medicaid managed care plan or Medicaid Fee for Service):

- Primary care service visits should be billed to Medicaid Managed Care.
- Substance use disorder service visits should be billed FFS.
- Mental health service visits should be billed FFS for SSI enrolled recipients and managed care for non-SSI enrolled recipients.

Service Type and Payer Type

Eligibility Status	Service Type		
	Mental Health Services	Primary Care Services	Substance Use Disorder Services
SSI *	Fee-for-Service	Medicaid Managed Care	Fee-for-Service
Non-SSI	Medicaid Managed Care	Medicaid Managed Care	Fee-for-Service

* Includes SED children that receive care at designated clinics.

Multiple service type visits which comprise any combination service types (primary care and mental health/substance use disorder) should be billed to payer type indicated:

- Primary care services and mental health services rendered to a non-SSI (SED) recipient should be billed to Medicaid Managed Care.
- Any combination of primary care services, mental health, and/or substance use disorder services rendered to SSI recipients should be billed FFS.
- Any combination of mental health and substance use disorder services rendered to a non-SSI recipient.

Service Type Combination and Payer Type

	SSI	Non-SSI
Medicaid Managed Care	NA	Bill for a combination of mental health and primary care services provided in a visit.
Fee-for-Service	Bill for any combination of two or more services including mental health, substance use disorder and primary care services provided in a visit.	Bill for a combination of mental health and substance use disorder services provided in a visit.

Note, although providers should make every effort to submit a single claim for each integrated service visit, there may be circumstances in which a provider will have to ‘split’ the claim so that the behavioral health service is billed directly to the recipient’s Behavioral Health Organization (BHO) and physical health/primary care service is billed to the recipient’s mainstream managed care plan. Beginning July 1, 2015, new APG logic changes will be implemented to mitigate existing fiscal disincentives that apply to multiple service type visits rendered by all existing or newly certified integrated services clinics.

- For all approved integrated services clinics, Medicaid will eliminate the 10 percent APG discount for multiple behavioral health services provided on a single day. The 50 percent physical health APG discount will remain in place.
- For approved mental health or substance use disorder behavioral care host clinics, Medicaid will eliminate the multiple Evaluation and Management (E&M) consolidation logic so that when two E&Ms are billed (e.g., one for physical health and a second for behavioral health), the APG grouper/pricer will no longer package the second E&M into the APG payment. Medicaid will pay integrated service providers \$75 for the second E&M if modifier “27” is appended to the second E&M. It should be noted that in order for the second E&M to pay at least one non-mental health and/or substance use disorder diagnosis code (e.g., ICD-9) will need to be included on the claim.

Medicaid managed care plans will be notified of the Department of Health’s Medicaid billing/reimbursement policies as they relate to the types integrated services rendered by approved providers, including statutory government rate protections for eligible populations that receive mental health and/or substance use disorder services.

It should also be noted that the 5 percent base rate bump which currently applies to all visits rendered by participating integrated services clinics under the Pilot will be discontinued effective June 30, 2015. Beginning July 1, 2015 all providers, including existing Pilot clinics, will be paid based on the revised integrated license APG visit logic and their regular base rate.