Comments on Proposed Subpart 599-1 Integrated Outpatient Services Regulation

The Community Health Care Association of New York State (CHCANYS) respectfully submits these comments in response to the proposed Integrated Outpatient Services Regulations issued by OMH. We appreciate the opportunity to comment and are very supportive of the concept of integrated service provider licensure, which aligns well with FQHCs' comprehensive care model. CHCANYS believes that streamlining the regulations for entities that provide integrated primary, behavioral and mental health care is integral to ensure superior coordination of care for the large number of patients with multiple diagnosis. However, as discussed in greater detail below, we do have some comments and questions about the regulations as drafted.

General Comments

1. A lead agency should be designated to administer the centralized integrated care application.

CHCANYS is very supportive of a centralized integrated care application for entities that provide different types of health care services at one location. However, we are concerned that the lack of a designated lead agency to implement and administer the application process may lead to differing interpretations of the regulations, which may cause confusion and uncertainty amongst providers. While the draft regulations clearly address three types of services at issues, they do not expressly address how the agencies would integrate their regulatory processes or expectations for service providers operating within this environment in regards to cross-training, communication, etc. to ensure consistency in application. Additionally, they do not make clear whether entities will also have to go through the Department of Health Certificate of Need process.

In order to ensure consistent interpretation and enforcement, CHCANYS believes it is important to designate one agency to lead the process, or at the very least, clearly delineate which agency administers which sections of the regulations.

2. Integrated services licensure should be available to entities beyond only those that currently hold dual licensure.

The proposed regulations require that participation in the integrated services initiative is limited to those entities that already hold dual licenses. CHCANYS believes that this limitation is unduly restrictive and overly burdensome to the many entities that are not currently dual licensed but are working towards an integrated care model. This is especially relevant under DSRIP or other agency initiatives to promote care coordination and integration and address service gaps in populations served by providers.

3. Integrated services providers should be permitted to be reimbursed for multiple threshold visits per day.

For Medicaid patients, the basis of payment for most clinic services provided in hospital outpatient departments and diagnostic and treatment centers under Article 28 of the Public Health Law is the threshold visit. A threshold visit "occurs each time a patient crosses the threshold of a facility to receive medical care without regard to the number of services provided during that visit." (New York State Department of Health (DOH) regulation at 10 NYCRR 86-4.9)

Section 599-1.3 indicates that the proposed regulations are in addition to existing Article 28, 31 and 32 regulations. This seems to put more burden and regulatory compliance on providers who decide to become "integrated service providers". As a respite from this additional burden, CHCANYS proposes that FQHCs that are approved to operate as licensed integrated service providers be permitted to bill for multiple threshold visits on the same day. Often, when a patient sees a different provider or returns the health center for a second or third visit on the same day, regardless of the type of service(s) being provided, these encounters are not covered by Medicaid. In many cases, the FQHC must rely on limited resources to cover the cost of these services for Medicaid beneficiaries. Allowing for multiple threshold visits would impose minimal to no impact on the agencies. Furthermore, permitting FQHCs to be reimbursed for multiple threshold visits closely aligns with FQHCs comprehensive care model and reflects the spirit of the integrated services program, in which licensed entities are permitted and encouraged to provide multiple types of care at one location.

4. The requirement for physical separation of space between types of service providers should be eliminated.

Sections 599-1.10 (c)(1)(i) states that "program space, except medical examination and treatment rooms, may be shared between certified outpatient services pursuant to an approved schedule. Individual and group rooms should not be utilized for multiple services simultaneously." This appears to maintain the existing regulatory scheme that requires separation of space between physical and behavioral care service providers.

CHCANYS feels that this physical space requirement is unwarranted and unduly burdensome to the many FQHCs that operate under small clinic initiatives and other waiver programs that typically serve medically underserved populations including the homeless, migrant workers, school based health centers and rural communities. These providers tend to serve patients who are much more likely to exhibit complex co-morbidities and yet have limited physical space in which to provide services. We request that the regulations be amended to permit sharing of physical space between physical and behavioral care providers who participate in the integrated services program.

Additional comments

1. Section 599-1.6 (b) states 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. Should all clinical areas of expertise be included in the board (e.g., if the host model is an substance use disorder center, should primary care clinical expertise have a voice on the governing body?)

2. Section 599-1.7 (e)(6) requires that a treatment plan identifies and documents "each diagnosis for which the patient is being treated at the program." Does this language mean that all diagnosis across all types of providers within the entity be documented or each diagnosis within each separate type of provider (ie behavioral health v. substance use disorder providers?)

3. Section 599-1.7 (g)(3) requires that periodic reviews of treatment plans include "an evaluation of physical health status." We recommend that this also include "and adjustment of any treatment plans to address physical health needs" to ensure that plans are updated to address patients' physical needs.

4. Section 599-1.7 (g)(4) requires that periodic reviews of treatment plans include "the signature of the qualified health professional, or other licensed individual within his/her scope of practice involved in the treatment." This is of particular concern to FQHCs who provide care under a comprehensive model that

includes several different professionals. Does this mean that the signature of one professional is required or that each professional on the team from each type of service provider must sign the treatment plan?

5. Section 599-1.9 (a)(2)(v) and (vi) limits OB/GYN primary care visits to routine care and family planning services and exclude prenatal care. It would seem that all these services are equally impacted by co-morbidities and should all be brought together into a single treatment plan. Is there a clinical reason these services are limited and/or excluded?

6. Section 599-1.14 (C)(3)(i-iii) delineates how long a provider must have been licensed or certified with each relevant agency in order to be consider "in good standing." OMH and OASAS licensed/certified programs are required to have 1 or 2-3 years, respectively, of partial or substantial compliance whereas there is no time requirement for providers licensed by DOH. Why is there a discrepancy between these requirements based on the licensing agency?

7. Section 599-1.14 (c)(5) requires that providers seeking to offer integrated care services must demonstrate that they are members of a health home. It seems unduly restrictive to require that providers be members of a health home. Does this requirement hold even if the provider is a member of a DSRIP provider performing system and not a health home?

8. Section 599-1.15 (d) references unannounced inspections that will occur prior to the renewal of the Operating Certificate or License. Does this mean that unannounced inspections will only occur prior to renewal and not prior to original joint-licensure?

9. Section 599-1.15(d)(1) notes that at the beginning of the inspection, the inspector will meet with the clinic staff to explain the purpose and scope of the inspection and request any relevant documents. CHCANYS is concerned that it may be difficult for busy clinical staff to interrupt their patient appointments to meet with the inspectors and provide the requested documentation.

10. Section 599-1.15(g) refers to a "fiscal viability review" which will require that information be submitted "in intervals" to determine the providers "fiscal capability to effectively support the authorized services." We would appreciate additional clarity on this review standard. Will providers be reviewed based on the viability of the integrated services or the entire organization or their ability to provide capital or another standard?