DSRIP PPS Requests for Waiver of Regulations: Update and Focus On Integrated Service Delivery Projects

The following are some of the specific regulatory requirements that PPSs should consider requesting regulatory and mandate relief to more effectively and efficiently implement the integration of health and behavioral health services. ***This list document is not intended to represent an exhaustive list of all the regulations a PPS should consider in its regulatory waiver application.***

UPDATE FROM DOH

The following update is based on questions we asked DOH this week and answers they provided. While not officially published on the DOH website, we hope this is helpful.

- In contravention to the rumor mill, DOH will **not** be imposing limits on the number of regulatory waiver requests a PPS can make.
- DOH is open to talking to PPSs about questions they have about this aspect of their application, although it should be noted that the PPS likely has thought about the intricacies of its requests and how they relate to its specific projects more than DOH has or, perhaps, could.
- While every PPS must be as thorough and as complete by Dec. 22 as possible, this is not a snooze or lose or a "gotcha" exercise. DOH will publish the list of regulatory waivers requested, and if a PPS realizes after the date that it should have asked for one, it can. If a waiver was denied for, e.g., lack of sufficient information, it can resubmit. This will be on a rolling basis.
- DOH is not going to publish updated guidance, but they anticipate that publication of the regulatory waivers actually requested/given should be helpful to the PPSs.
- Regarding PPS patient data sharing, DOH is working on a uniform consent form, but it will not be ready by Dec. 22. Even though the form will not be ready, earlier publication of the fact that DOH is working on the form was meant to **discourage** PPSs from asking for waiver of patient privacy/ regulations that would restrict information sharing (which DOH thought would be difficult to waive in any event).
- Regarding the Proposed Integrated Services regulations (HERE) which are not yet finalized, the question was asked whether PPSs should assume finalization, and if so, whether they were meant to restrict options for PPSs (e.g., encourage PPSs to use the integrated licensure model v. requesting waivers of existing regulations in place that would limit the ability to integrate). The answer: the integrated regulations are expected to be final. While DOH would hope that providers would avail themselves of this new regulatory structure, DOH recognized that it is limited and that PPSs may prefer to seek regulatory waivers rather than get component entities to get dual licensure, etc. While the integrated licensure regulations are "just one model," PPSs should review the integrated regulations as those regulations would "guide" DOH's thinking on related requests.

FOCUS ON INTEGRATED SERVICE DELIVERY PROJECTS

Exemption from Restrictive Scopes of Professional Practice. The State Education Department regulates the health and behavioral health professions, including but not limited to medicine, nursing, psychology, social work and mental health practitioners. But remember, under this Regulatory Waiver Process, SED regulations can **not** be waived. What other options are there?

Each PPS should consider requesting DOH to work with the State Education Department and to approve the PPS and its partners to be exempt from restrictive scope of practice requirements, provided that this does not result compromise patient safety.

Under current law, persons employed in programs that are operated, regulated, funded, **or approved** by several State agencies, including DOH, OPWDD, OMH, and OASAS (as well as local mental hygiene departments and local social services districts) are exempt from the licensure requirements applicable to the professions of Social Work, Psychology, and Mental Health Practitioners, and therefore those programs are permitted to employ persons without being limited by the restrictive "scope of practice" requirements of those professions. This limited exemption from these licensure requirements will expire by July 1, 2016, if it is not again extended. [Note: the term "Mental Health Practitioner" is the term used in the Education Law to refer to the four professions of Mental Health Counseling, Marriage and Family Therapy, Creative Arts Therapy, and Psychoanalysis.]

To ensure that Integrated Delivery Systems and their treating partners do not run afoul of these scope of practice restrictions, and to provide maximum flexibility and to employ staff in the most efficient manner possible, PPSs should request that DOH exercise its authority under current law **to formally approve each PPS and its treating partners in order to become exempted from these scope of practice provisions for the professions of**:

- **Social Work** (Education Law, Article 154),
- **Psychology** (Education Law, Article, 153), and
- **Mental Health Practitioners** (Education Law, Article 163).

The specific authority for DOH to approve programs, and thereby qualify for the exemption from scope of practice restrictions of the various professions are located in:

- Section 9 of Chapter 420 of the Laws of 2002, as amended by chapter 132 of the laws of 2010, relating to the profession of social work
- Subdivision a. of Section 17-a of chapter 676 of the laws of 2002, as amended by chapters 130 and 132 of the laws of 2010, and as further amended by chapter 57 of the laws of 2013, in relation to the profession of psychology and the four professions described as mental health practitioners.

Furthermore, PPSs should consider advocating for the extension of this scope of practice exemption beyond its July 1, 2016 sunset date.

Prohibitions Against Fee-Splitting (10 NYCRR § 600.9). This regulation prohibiting fee splitting or sharing in gross revenues of non-established entities should be waived with respect to the financial components of any agreements dictating the flow of dollars, such as distribution of DSRIP proceeds among PPS providers sharing a patient population. Waiver of this regulation should be considered in any integrated service project.

Patient transfers and discharges. Currently, various agencies have rules and regulations governing patient transitions. These processes must be waived or streamlined in an integrated environment. Regulations to consider include:

- 10 NYCRR §§ 405.9, 400.9, 400.11, 700.3, 415.38
- 18 NYCRR §§ 505.20 and 540.5
- 14 NYCRR § 36.4 and 14 NYCRR § 504.5 (governing community placement after IP behavioral health discharge)
- 14 NYCRR Part 815.7 (regarding discharge from OASAS services)

Credentialing. Practitioner credentialing and the ability for practitioners to treat patients throughout a PPS is essential. Effective PPS credentialing will require application of a single system wide credentialing process, and waiver of various state agency requirements. Administrative delays relating to multiple credentialing processes of the State and managed care organizations can impede a PPS's ability to provide access to care, and this is particularly true given that credentialing processes are not tailored to recognize a PPS structure. A PPS should ask the State to develop an expedited single credentialing process that will meet the needs of the PPS and address quality and liability concerns of the State and payers. Regulations to consider include the following:

- 14 NYCRR Part 853 (OASAS Providers)
- 10 NYCRR Parts 94 and 707 (Governing physicians' assistants)
- 10 NYCRR §§ 405.2 and 405.4 (hospitals)

[Note that this request for a single waiver process would not be applicable to the credentialing of ***peers*** *by OASAS or OMH.]*

Certificate of Need (CON) and Prior Approval Review (PAR) Regulations and Processes
Many requirements defining actions that trigger a CON review are regulatory. The overarching principle for requesting waiver of CON/PAR regulations/requirements is that most, if not all, of the PPSs will engage in activities or transactions that require various levels of CON/PAR approval, which can be time consuming and constrictive – particularly if the PPS is engaged in transformative work that does not conform to traditional CON/PAR projects.

<u>Behavioral Health PAR Regulations.</u> Specific regulations governing authorization of construction, acquisition or operation of behavioral health facilities or services include the following, which a PPS should consider requesting waiver:

- 14 NYCRR Part 77 (governing physical plant standards for behavioral health facilities)
- 14 NYCRR Part 321 (regarding financing and constructing substance use disorder facilities)

- 14 NYCRR Part 521 (regarding financing assistance for capital construction or acquisition of behavioral health facilities)
- 14 NYCRR Part 551 (regarding expediting project reviews for OMH regulated facilities)
- 14 NYCRR Part 573 (regarding issuing operating certificates to OMH regulated providers)
- 14 NYCRR Part 810 (regarding establishing, certifying substance use disorder services)
- 14 NYCRR Part 814 (regarding OASAS facility requirements)
- 14 NYCRR Parts 620 and 621 (CON Process and financial assistance for construction or other capital projects under OPWDD jurisdiction)
- 14 NYCRR Part 635-6 (Permitted capital costs and transactions with related parties for OPWDD regulated entities)

Behavioral Health Regulations relating to the provision of behavioral/medical care. Regulatory requirements requiring behavioral health care professionals to take certain specific actions relating to provision of medical care.

Consider:

- 14 NYCRR Part 77 (governing physical plant standards for behavioral health facilities)
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- 14 NYCRR Part 521 (regarding financing assistance for capital construction or acquisition of behavioral health facilities)
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- 14 NYCRR Part 810 (regarding establishing, certifying substance use disorder services)
- 14 NYCRR Part 814 (regarding OASAS facility requirements)
- 14 NYCRR § 814.7 (governing spaces shared with substance use disorder services)
- 14 NYCRR § 36.4 and 14 NYCRR § 504.5 (governing community placement after IP behavioral health discharge)
- 14 NYCRR Part 815.7 (regarding discharge from OASAS services)
- 14 NYCRR Part 506 (rates and standards relating to intensive case management)
- 14 NYCRR § 507.7 (standards for participation in community based behavioral health services for children)
- 14 NYCRR Parts 510 & 520 (accessing or correcting OMH records)
- 14 NYCRR Parts 803 & 804 (accessing OASAS records)
- 14 NYCRR Part 511 (standards and rules around personalized recovery oriented services (PROS))
- 14 NYCRR § 527.6 (rights of behavioral health IP patients to object to treatment)
- 14 NYCRR Part 587 (regarding standards and requirements for operating outpatient behavioral health programs, including day treatment, partial hospitalization and other types of programs, and record retention/sharing of such programs)
- 14 NYCRR Part 599 (regarding standards and requirements for clinic treatment programs)
- 14 NYCRR Part 592 (Governing Comprehensive Outpatient Programs)
- 14 NYCRR Part 594 (Governing Operation of Licensed Housing Programs for Children and Adolescents with severe emotional disturbances)

- 14 NYCRR Part 595 (governing operation of residential programs for adults)
- 14 NYCRR Part 816 (governing IP and OP chemical dependence withdrawal and stabilization)
- 14 NYCRR Part 819 (governing standards, operation, staffing for chemical dependence residential services)
- 14 NYCRR Part 822-2 (governing outpatient chemical dependency and opioid treatment)
- 14 NYCRR Part 822-4 (regarding staffing, treatment plans, etc., for outpatient chemical treatment programs)
- 14 NYCRR Part 822-5 (regarding opioid treatment programs)
- 14 NYCRR Part 823 (governing standards, admissions, record keeping treatment plans of chemical dependency OP services for youth)
- 14 NYCRR Part 831 (OASAS administrative appeals)

(Please note that requests for regulatory waivers must cite to specific regulations, sections, and subsections, and explain with specificity why the waiver is needed in relationship to the specific project e.g., Integrated Delivery System project. Since waivers do not automatically apply to all partners within a PPS, the request should indicate whether all or only some named partners require the waiver.)

Co-location. As noted above, the State licensing agencies have promulgated proposed regulations (HERE) to permit, under certain circumstances, the co-location of clinic programs licensed by multiple agencies at a single site. These regulations are written in a manner intended to permit co-location of these programs, while reducing the regulatory burden to the provider of the co-located programs.

As noted above, there is no limitation that would prohibit PPSs from requesting regulatory relief beyond these proposed regulations. Given the focus of DSRIP on developing integrated delivery systems, particularly addressing integration of behavioral health and medical care, any PPS should request waiver of all State regulatory impediments to the co-location of services (i.e., co-locating services licensed by DOH, OMH, OASAS, OPWDD and/ or private practices) to support PPS partnerships and implementation of DSRIP projects. Such waivers could redirect some patients away from the ED and reduce hospital admissions through availability of primary and secondary care.

Additionally, because not all restrictions against co-location are imposed by the State, a PPS should request that the State petition CMS for the authority to waive its regulations pertaining to the co-location of services when it is deemed to be in the best interests of promoting the objectives of DSRIP.

Specific State regulations that may pose barriers to co-location include, but are not limited to:

- 10 NYCRR Part 83 (Shared Health Facilities)
- 14 NYCRR § 814.7 (governing spaces shared with substance use disorder services)

- 14 NYCRR Part 511 (standards and rules around personalized recovery oriented services (PROS))
- 14 NYCRR § 527.6 (rights of behavioral health IP patients to object to treatment)
- 14 NYCRR Part 587 (regarding standards and requirements for operating outpatient behavioral health programs, including day treatment, partial hospitalization and other outpatient programs, and record retention/sharing of such programs)
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Multiple Agency Reviews and Approvals. All PPSs should request that approvals required from multiple State agencies for co-located projects should be consolidated into a single review process by the State, including all CON or Prior Approval Review (PAR) processes. Further, PPSs should request exemption from separate Public Need and Financial Feasibility reviews (both of which will be covered under State's review of the PPS). 10 NYCRR § 600.1 and Parts 670 and 700.

- *Generally:* The PPS should recommend that the Public Health and Health Planning Council (PHHPC) schedule bi-weekly videoconference meetings, and the Behavioral Health Services Advisory Council should schedule monthly videoconference meetings, to accommodate any required approvals emanating from approved PPSs.
- *Relocations:* Bed and service relocations between established providers in approved PPS should only require letter notification to DOH and other agencies, and a maximum time frame of DOH/agency approval of 15 days. This recommendation is modeled after 10 NYCRR 708.3 and 708.4 (appropriateness review procedures) and 710.1(c)(iv)(d); 710.1(c)(ii)(5)(g) (service relocations).
- *Facility and service closures*: A PPS might recommend replacing the 90-day DOH timeline with a maximum 30-day timeline. 10 NYCRR 401.3(g).