INTEGRATED PRIMARY CARE AND BEHAVIORAL HEALTH SERVICES FOR OLDER ADULTS

Options for New York State Providers
Acknowledgements

“Integrated Primary Care and Behavioral Health Services for Older Adults: Options for New York State Providers” was developed for the Geriatric Technical Assistance Center operated by the National Council for Behavioral Health, with funds made possible by the New York State Geriatric Mental Health Act. The scope of this guide addresses behavioral health services (including addictions) but does not specifically address substance abuse services. Information contained in this guide is accurate as of December 31, 2013 and is not intended to be a substitute for reading applicable federal and state laws and regulations. The statements, findings, conclusions, and recommendations do not necessarily reflect the view of the New York State Office of Mental Health.
# Table of Contents

Acknowledgements .................................................................................................................. 2  
Preparing for Integration ........................................................................................................ 4  
  
  Introduction .......................................................................................................................... 5  
  
  Purpose of this Guide .......................................................................................................... 5  
  
  A Standard Framework for Levels of Integrated Healthcare .............................................. 5  
Integration Options for New York State Providers .................................................................. 6  
  
  Model 1: Integration of Physical Healthcare Services into a Mental Health Clinic ............. 6  
  
  Model 2: Integration of Behavioral Healthcare Services into a Primary Care Clinic .......... 10  
Financing Integration ............................................................................................................. 13  
  
  Medicare and Medicare Part B Services ............................................................................. 13  
Resources .................................................................................................................................. 14  
Appendix A: Standard Framework for Levels of Integrated Healthcare .............................. 15  
Appendix B: Licensure of Clinics and Individual Practitioners ............................................. 19  
Appendix C: Required and Optional Article 31 Service Definitions and Guidance .............. 23  
Appendix D: Practitioner Reimbursement Under Medicaid Part 599 and Medicare Part B .. 25  
Appendix E: Article 28 Extension and Part-Time Clinics ....................................................... 26  
Appendix F: Medicare Part B ................................................................................................. 27
Preparing for Integration

INTRODUCTION

With an aging baby boomer generation, New York State, like the rest of the country, is on the verge of an “elder boom.” By the year 2030, New York expects to see a 50% increase in the number of older adults. Consequently, the state anticipates an increase in the number of older adults with diagnosable mental illness from 495,000 to approximately 772,000. This boom, and the unique service needs of the older adult population, presents an urgent need for behavioral health and primary care providers to adjust their practices.

For example, depression is acknowledged as the most prevalent mental health problem among older adults and is associated with impairments in physical, mental and social functioning. The incidence of depression in the elderly (over 65) is approximately six percent in any given year; 25 percent of those living with another chronic illness experience depression and 50% of nursing home residents experience depression. Older adults with depression visit the doctor and emergency room more often, use more medication, incur higher outpatient charges, and stay longer in the hospital. Moreover, the presence of depressive disorders often adversely affects the course and complicates the treatment of other chronic diseases.

Given the statistics on depression alone, it is clear that the unique needs of older adults are best met in a system where no division exists between physical and behavioral health services. At a minimum, such a system has a high degree of care coordination; ideally, such a system is evolving rapidly across the integration continuum towards full collaboration among health providers serving the older adult population. There is growing evidence that integrated care is vital for this population. Recent data have shown that collaborative care models result in better patient outcomes than traditional models of care. These models can also be delivered at the same cost as traditional models of care, and can be associated with lower total health care costs among older adults.

In an effort to break down the silos that have divided services for older adults, New York State passed in 2005 the Geriatric Mental Health Act, which established the authority and funding for demonstration programs that would integrate physical and behavioral health care for older adults. Since then, over three dozen programs have been funded to deliver bidirectional integrated health services, and the models outlined in this guide reflect the diversity of approaches taken by those programs.

PURPOSE OF THIS GUIDE
The purpose of this guide, *Integrated Primary Care and Behavioral Health Services for Older Adults*, is to offer guidance to New York State healthcare providers that are considering moving toward integrated care. This guide:

- Describes several models of integration feasible under current New York State and Federal law,
- Outlines the pros and cons of those models, and
- Provides an introductory primer on how to finance service delivery under those models.

The field of care integration is evolving. Providers must recognize that there is no one-size-fits-all model, and that the path an organization pursues is influenced by state and federal policy, organizational resources, community assets, and patient needs. This guide intends to help healthcare providers in New York State begin or continue their integration journey with information and resources for success.

A STANDARD FRAMEWORK FOR LEVELS OF INTEGRATED HEALTHCARE
For the past five years, the SAMHSA-HRSA Center for Integrated Health Solutions (CIHS) has led the national dialogue on integrated care. While that project has focused specifically on bringing primary care into behavioral health organizations, the work has included developing principles that support the development of models of integrated care and a framework to guide providers in thinking about their work in integrated care.

Given the wide and inconsistent use of the term “integration,” in April 2013 CIHS released “A Standard Framework for Levels of Integrated Healthcare,” which aimed to standardize the classification of integrated settings. The framework outlined six levels of integration with key elements distinguishing one level from another:

**COORDINATED CARE**
- Level 1: Minimal Collaboration
- Level 2: Basic Collaboration at a Distance

**CO-LOCATED CARE**
- Level 3: Basic Collaboration Onsite
- Level 4: Close Collaboration with Some System Integration

**INTEGRATED CARE**
- Level 5: Close Collaboration Approaching an Integrated Practice
- Level 6: Full Collaboration in a Transformed/Merged Practice

In the report and its accompanying charts, each level is differentiated by key features, including:

- How behavioral health, primary care, and other healthcare providers work together
- Clinical delivery practices
- Patient experience
- Practice/Organizational leadership
- Business models

The *Standard Framework* is recommended reading as you consider your approach and the charts are included in Appendix A.

In addition to the *Integration Framework*, the SAMHSA-HRSA Center for Integrated Health Solutions also offers many resources for organizations pursuing integration, including organizational self-assessment tools in areas ranging from partnerships, workforce development, and integrated treatment planning to health and wellness, billing and finance, and HIT.
Integration Options for New York State Providers

This section will outline six different options for New York State providers to integrate behavioral and physical healthcare services, which are consistent with the CIHS Standard Framework. Three approaches add physical healthcare services to a mental health clinic (Model 1 as designated in New York State’s geriatric service demonstration program) and three approaches add behavioral health services to a primary care setting (Model 2). Many of these models have been tested by demonstration programs overseen by the Office of Mental Health (OMH) and with resources made available by the New York State’s Geriatric Mental Health Act.

MODEL 1: Integration of Physical Healthcare Services into a Mental Health Clinic

This section outlines three options for integrating physical healthcare services into an Article 31 clinic:

1. **EXTERNAL PARTNERSHIP WITH AN ARTICLE 28**: collaborating and co-locating with another organization’s Article 28 Diagnostic and Treatment Center.

2. **INTERNAL PARTNERSHIP WITH AN ARTICLE 28**: collaborating and co-locating with an Article 28 under the same ownership as the Article 31.

3. **SELF-CONTAINED**: reliance on services available to Article 31 clinics through Medicaid Part 599 and Medicare regulations.

Option 1: External Partnership with an Article 28

Under this model, Article 31 clinics develop a formal partnership with an external provider of Article 28 services to provide physical healthcare services on-site at the Article 31 clinic.

The advantages of this arrangement are many:

- **EXPANDS CAPACITY**. Depending on whether the Article 28 pursues an Extension or Part-Time clinic (see box), it is possible for clients to truly have a “one-stop shop” for their primary care and behavioral health care needs. The alliance with an Article 28 clinic/clinician broadens the array of available evaluation and treatment services covered by Medicaid, and also creates an opportunity for increased services to Medicare and Commercial Insurance clients.

- **ORGANIZATIONAL EFFICIENCY**. Infrastructure and expertise are already in place at the partnering (Article 28) organization for credentialing and billing Medicaid, Medicare, and other insurers for physical healthcare services.

ARTICLE 28

Extension vs. Part-Time Clinics

Article 28 clinics that want to expand their services to a new location have two options: create an Extension Clinic or a Part-Time Clinic.

*Extension Clinics* are clinics that provide services of a non-emergent nature at a site other than the premises of the sponsoring Diagnostic and Treatment Center (D&TC). They may be certified to provide services other than or in addition to the services provided at the sponsoring center, provided they are authorized to be provided by a D&TC.

*Part-Time Clinics* have more limitations than Extension Clinics. Part-Time Clinics may provide no more than 60 hours of services per month and only provide services that are deemed “low risk.” Part-Time clinics also are not expected to be the ongoing source of primary care services for the patient.

Both options require review and approval by the NYS Department of Health.

See Appendix E for additional detail.
**EXPANDS PROVIDER NETWORK.** Article 28 clinics have experience recruiting physical healthcare professionals and, in the case of nurse practitioners, establishing cooperative physician agreements.

**SERVICE EFFICIENCY/CARE COORDINATION.** There is far greater opportunity for true integration of physical and behavioral health care services when services are provided in the same physical space; the ease of communication and movement between the services is enhanced.

This model requires a significant investment of time and resources by both partner organizations. Among the considerations are:

- Architectural and physical plant changes at the Article 31 to conform to Article 28 requirements (i.e. infection control measures, sinks, hazardous waste disposal etc.)
- Time investment necessary to secure licensure changes through the Department of Health
- Decision about how health records will be shared between the two organizations. In some cases the organizations can create sharing between electronic health records, but in others plans will need to be made for sharing key information on paper. Ideally the decisions about what information is important to be shared can be made in a collaborative process between the two organizations.
- Establishing workflow that supports the increased communication (face-to-face and electronic) that is required to achieve integration. The presence of both physical health and behavioral health providers in the same physical space increases the opportunities for collaboration but experience has shown that without intentional planning these opportunities will not be maximized.
- Creation of common problem lists and care plans.
- Team meetings.
- Time investment necessary on the part of leadership from both organizations to build a solid foundation and partnership for a healthy and sustainable collaboration.

This option is ideal for organizations that have the long-term strategic vision and commitment to serve as the primary care provider for their behavioral health clients, as well as the capital and time resources necessary to invest at the start of the project.

**Option 2: Internal Partnership with an Article 28**

Under this option, the Article 31 "partners" with an Article 28 that is owned and operated by the same organization as the host Article 31 clinic. This option and its considerations are very similar to those just outlined under Option 1: External Partnership with an Article 28, but has some special considerations given that the two clinics already have a formal relationship through their common ownership.

This option shares some of the same advantages as Option 1 above:

- Existing expertise with billing and credentialing.
- Existing expertise in workforce issues.

In addition, a shared organizational vision should make financing the necessary structural changes easier.
Even though the programs share the same organizational structure, there are important considerations to advance this integration model:

- Leadership from the top is vital to developing the vision and communicating it to staff at the practice level.
- Active, inclusive planning is essential to generate staff enthusiasm and buy-in.
- Communication must occur with the people being served by the organization about the new direction and include input in planning workflow and integration strategies.
- Clear planning around sustainability, financial impact and strategic development.

*This option is ideal for organizations that already have multiple service arms and are looking to integrate them on a clinical level for clients.*

---

**SPECIAL NOTE: FEDERALLY QUALIFIED HEALTH CENTERS (FQHCS)**

As “safety net” providers, Federally Qualified Health Centers (FQHCS) are certified under federal guidelines and licensed by New York State. There are FQHCS that are only Article 28-licensed, both Article 28- and 31-licensed, and some are “hospital-based” (both in the state and federal definitions). Most FQHCS in New York State are paid under a completely different payment system than Article 28 or 31 clinics in New York and, by virtue of their federal standing as an FQHC, are allowed to provide certain basic services (referred to as the scope of services) that include most all primary care services, many preventive services and the services of psychologists and social workers. Provided the services are in their scope of work, FQHCS are able to be reimbursed for more behavioral health services than an organization that is only licensed as an Article 28.

FQHCS, with some exceptions, are reimbursed for providing most all services that are considered in an integrated care program. However, they are not paid based on the type or number of procedures but rather are paid a single fee per “encounter.” For more information regarding FQHCS and reimbursement, both the National Association of Community Health Centers (NACHC) and the Community Health Center Association of New York State (CHCANYS) are excellent resources.

---

**Option 3: Self-Contained Article 31**

In this option, the Article 31 hires or contracts with physical healthcare staff directly, and relies on the authority granted via Part 599 regulations to provide physical healthcare services to their Medicaid-only population. Clinics can, and should, also take into account services that can be billed to Medicare, private payers, and other types of insurance, but the ability to bill Medicaid under this option is restricted to services outlined under Part 599 regulations (see box).

Part 599 regulations allow Article 31 clinics, at their option, to provide “health physicals” and “health monitoring” services under Medicaid, on condition that the services are:

1. Added to the clinic's operating certificate,
2. Provided by approved health care professionals, and
3. Provided within the guidelines outlined in the Office of Mental Health's Part 599 guidance.
The Self-Contained option has an easier start-up process than the options previously outlined. Unlike strict architectural requirements outlined by the Department of Health for Article 28 D&TCs, Article 31 clinics providing healthcare services need only meet “adequate and appropriate” standards for their physical plant.6

The biggest challenge that Article 31s face when pursuing this option is how to financially sustain a position for a physical healthcare practitioner. Clinically, a registered nurse may be the best fit for an organization planning to provide a limited array of physical healthcare services. Registered nurses, however, are not authorized to provide the higher-paying “health physicals” under Part 599 regulations and, therefore, organizations become restricted in their ability to bill both Medicaid and Medicare for health physicals. Nurse Practitioners, on the other hand, are difficult to financially sustain when health physicals are limited to one per year and health monitoring reimbursement rates are relatively low. One option is to recruit a Psychiatric Nurse Practitioner to the organization. This strategy provides multiple benefits, including the ability to:

See Appendix D for a table of services covered under Medicare and Medicaid Part 599, delineated by type of practitioner.

PART 599 HEALTH SERVICES IN ARTICLE 31 CLINICS

Health Physical:
- A health physical is the physical evaluation of an individual, including an age and gender appropriate history, examination, and the ordering of laboratory/diagnostic procedures as appropriate.
- This service must be provided by a physician, nurse practitioner (including psychiatric nurse practitioner), or physician’s assistant.
- No more than one health physical may be claimed in a year.
- It is claimed with a health service rate code and is excluded from the utilization threshold count.

Health Monitoring:
- Health monitoring is the continued measuring of specific health indicators associated with increased risk of medical illness and early death. For adults, these indicators include, but are not limited to, blood pressure, body mass index (BMI), substance use and smoking cessation. This service includes individual and group smoking cessation counseling.
- This service must be provided by a physician, nurse practitioner (including psychiatric nurse practitioner), physician’s assistant, registered nurse, or licensed practical nurse. Smoking Cessation Counseling must be provided by an MD, NPP, PA or RN.
- There is no annual limit to health monitoring services, but the reimbursement rate is low.
- Allowable if it is claimed with a health service rate code and excluded from the utilization threshold count.

See Appendix C for additional information about optional and required services for Article 31 clinics.

The Self-Contained option has an easier start-up process than the options previously outlined. Unlike strict architectural requirements outlined by the Department of Health for Article 28 D&TCs, Article 31 clinics providing healthcare services need only meet “adequate and appropriate” standards for their physical plant.6

See Appendix D for a table of services covered under Medicare and Medicaid Part 599, delineated by type of practitioner.

6. Article 31.05 accessed at http://law.onecle.com/new-york/mental-hygiene/MHY031.05_31.05.html
provide psychiatric evaluations and medication management,
provide basic-level physical health care evaluations and screenings,
draw down the physician add-on modifier under Medicaid (which is not available to nurse practitioners without a psychiatric specialty), and be flexible when seeking reimbursement from Medicare.

Organizations choosing to hire a Psychiatric Nurse Practitioner should be aware that not all psychiatric NP’s are interested in providing these physical health services and, if they are interested, their productivity expectations will need to be adjusted to allow time for this additional role.

To provide the best care for their clients, clinics that choose the Self-Contained option should still develop formal relationships with external primary and specialty care providers to assure the referral loop is complete for clients who receive the bulk of their physical healthcare services off-site. It is also important to look at the existing staffing composition and identify which staff will take the lead in care coordination between these external primary and specialty providers and the health care staff at the Article 31 clinic. Care coordination should include: medication reconciliation, extra support during care transitions, a coordinated crisis plan that includes physical health issues and support in preparation and follow up for physical health appointments.

*This option is best for mental health clinics that have limited space and capacity to make physical plant changes necessary to license an Article 28 clinic and/or have a client base with existing, strong primary care relationships.*

**Model 2: Integration of Behavioral Healthcare Services into a Primary Care Clinic**

This section outlines three options for integrating behavioral healthcare services into an Article 28 clinic:

4. **EXTERNAL PARTNERSHIP WITH AN ARTICLE 31:** collaborating and co-locating with another organization’s Article 31 Mental Health Clinic.

5. **INTERNAL PARTNERSHIP WITH AN ARTICLE 31:** collaborating and co-locating with an Article 31 under the same ownership as the Article 28.

6. **SELF-CONTAINED ARTICLE 28:** reliance on services available to Article 28 clinics through Department of Health Part 86 and Medicare regulations.

**Option 4: External Partnership with an Article 31**

In this option, the Article 28 partners with an externally owned and operated Article 31 clinic. The full list of required and optional services for Article 31 clinics can be found in Appendix C, and include:

- Initial and psychiatric assessments;
- Individual, family and group psychotherapy;
- Psychotropic medication treatment, including monitoring and evaluating treatment response; and
- Crisis intervention to address acute distress and immediate needs.

**ARTICLE 31 SATELLITES** are any location where scheduled services are provided on a regular and routine basis (full- or part-time).

In determining the regular and routine nature of services at a given site, the Office of Mental Health takes into consideration the volume of services, the number of recipients receiving services, the number of staff assigned, the range of services provided, and whether the site will be utilized on a permanent or temporary basis.
To provide services at a new location, the Article 31 must receive approval from the Office of Mental Health to operate a “Satellite Clinic” [see box] and adhere to all Article 31 regulations and Standards of Care. Required services must be available at all primary clinic sites but not necessarily at each satellite site. Clients who require a required service or procedure that is not available at the satellite location must be linked to the primary clinic site for this service/procedure.7

In addition to the Medicaid-covered services guided by Part 599 regulations, the clinic may take advantage of Medicare and private insurance coverage that likely exists among the payer mix for the primary care clinic. The behavioral health clinicians hired to deliver services, however, must be among those approved for services by those payers. As will be discussed in the section on financing, an organization must have practitioners authorized to deliver covered services to a population insured or able to pay for services. [Also, see box for information regarding clinic and practitioner enrollment under Medicare.]

Advantages to this approach:

- The Office of Mental Health has streamlined and prioritized the approval process for Article 31 satellites in order to facilitate integrated care.
- Physical plant requirements for adding behavioral health services are significantly simpler than adding physical healthcare services.
- Potentially brings the full array of Article 31 services to the primary care setting.
- Provides an initial opportunity for strategic partnering that can then be expanded as the organizations’ comfort level with each other increases.
- Provides on-site behavioral health services for people in a convenient location.
- The behavioral health partner brings experience with documentation and billing for behavioral health services

This approach also has some inherent challenges:

- The regulations do not allow for a fluid model of integration and require that traditional outpatient services (including their documentation requirements) are transplanted into the primary care clinic.
- Preparing the primary care staff for the addition of this new colleague requires planning and attention.
- Substantial clinical leadership is required in order to create open communication between the “behavioral health” and “primary care” sides of the program as it is easy for “silos” to persist.

This option is best for organizations that have a substantial Medicaid population and want to access specialty behavioral health services for their clients.


**MEDICARE ENROLLMENT FOR BEHAVIORAL HEALTH SERVICES: CLINIC VS. PRACTITIONER**

Unlike under New York State Medicaid, most insurers enroll individual practitioners rather than “clinics.” In Medicare, for instance, there is no category of “mental health clinic.” Rather, individual practitioners such as Licensed Clinical Social Workers, Clinical Psychologists, Nurse Practitioners, and Physician-Psychiatrists enroll individually in the program. Payment can then be “assigned” to a designated organization. (Note: Under Medicare Part B, “Community Mental Health Center” refers only to providers of partial hospitalization services.)

For more information, see Appendix A: Licensure of Clinics and Individual Practitioners.
Option 5: Internal Partnership with an Article 31
Under this option, the Article 28 “partners” with an Article 31 that is owned and operated by the same organization. Many of the same challenges and opportunities arise under this option as in Option 4: External Partnership with an Article 31, including the ability to:

- Provide on-site behavioral health services for people in a non-stigmatizing environment.
- Align behavioral health and primary care treatment plans and goals for people with serious behavioral health concerns

Common ownership of the two clinics facilitates communication of the vision, but strong leadership is still necessary to communicate that at the practice level. Moreover, such leadership is necessary to developing common problem lists, treatment plans and establishing regular team communication.

In addition, there may be the tendency to ignore the intentionality that is required to truly integrate these services. There can be a tendency to assume that since everyone works for the same organization communication will just “happen”. This is not the case in most situations and requires the same planning and tracking of communication as in the other models of integration.

This option is ideal for organizations that already have multiple service arms and are looking to integrate them on a clinical level for clients.

Option 6: Self-Contained Article 28
Under this option, the organization provides only the short-term behavioral health services that are allowable under their Article 28-related Part 86 licensure, Medicare, and other insurers, but forgoes the specialty behavioral health services billable under Part 599 by an Article 31 clinic. [See Appendix C for the list of required and optional services for Article 31 clinics.]

Under Part 86, only individual psychotherapy is a covered service; group therapy is not an option.

Medicare and other insurers, however, often have a wider range of covered services. Medicare covered services include health and behavior interventions that target the underlying bio-psychosocial factors affecting physical health conditions, depression and alcohol misuse screenings, SBIRT, individual and group therapy, and family medical psychotherapy.

This option is best for Article 28 clinics that have assessed the clinical needs of their patient base, identified them as falling outside the realm of serious mental illness and therefore, do not anticipate needing access to a wide array of specialty or long-term behavioral health services.

---

INDIVIDUAL PSYCHOTHERAPY SERVICES AT ARTICLE 28 CLINICS
Article 28 clinics may provide individual psychotherapy services in only limited circumstances:

- When the clinics is designated as a FQHC, FQHC Look-alike, or Rural Health Center and approved by the Office of Health Systems Management (OHSM) to provide psychotherapy as noted on the clinic’s operating certificate; or
- When the clinic is providing services to children and adolescents up to 21 years of age or pregnant women up to 60 days postpartum.

WHEN SHOULD AN ARTICLE 28 BE LICENSED BY THE OFFICE OF MENTAL HEALTH?
An Article 28 clinic must review the need for an OMH license when:

- They provide more than 10,000 mental health visits annually, or
- Their mental health visits comprise over 30 percent of their total annual visits.
Financing Integration

To evaluate which integration model works best for your organization, it is important to understand the licensure and financing sources for mental health and physical healthcare services in New York State.

When considering what array of services an organization (or combination of organizations) is going to offer their clients, there are three important factors that must be considered with respect to financing the services:

1. Licensure of the clinic and its individual practitioners
2. Insurance mix of the organization’s current and/or target population
3. Benefit policies of the insurers

All of these components must be considered: an organization must have the practitioners authorized to deliver covered services to a population insured or otherwise financially able to pay for the services rendered.

Appendices B through F include detailed descriptions of the services and licensure requirements under Medicaid and Medicare:

- Appendix B: Licensure of clinics and individual practitioners
- Appendix C: Required and Optional Article 31 Services Definitions and Guidance
- Appendix D: Practitioner Reimbursement under Medicaid Part 599 and Medicare Part B
- Appendix E: Article 28 Extension and Part-Time Clinics
- Appendix F: Medicare Part B

MEDICARE AND MEDICARE PART B SERVICES

Clinics pursuing integration for older adults would be remiss to not consider the impact of Medicare financing to support their services. The federal Medicare program covers over 48 million lives nationwide and insures 3 million people in the State of New York. Medicare eligibility is typically based on either age (over 65) or disability. In 2010, 83% of beneficiaries were enrolled based on age, and 17% were enrolled based on disability.8

Broadly defined, Medicare has four benefit categories: Part A for Hospital Insurance, Part B for Supplementary Medical Insurance, Part C for Managed Medicare (also known as Medicare Advantage or MA) and Part D for Prescription Drug coverage (PD). Due to recent changes in the Medicare Advantage program, many Prescription Drug programs are administered by Medicare Advantage plans. This has resulted in hybrids referred to as MA-PD plans. Part B, which includes most outpatient healthcare services, is the primary focus of this paper’s discussion of integrated primary and behavioral healthcare services. Medicare Advantage plans, of which there are many in New York State, must cover the same as traditional Medicare Part B, though there may be differences in provider reimbursement amounts or methodology.

In New York, 26% of Medicare enrollees are dually-eligible for both Medicaid and Medicare. When a client is enrolled in both insurance programs, Medicare is the primary payer and Medicaid is the payer of last resort. Provider must bill Medicare first, and then bill Medicaid for co-insurance and non-covered services.

Resources

NEW YORK STATE

- Part 599 Clinic Treatment Programs: Regulations, http://www.omh.ny.gov/omhweb/policy_and_regulations/Adoption/Part_599_20120227.html

MEDICARE

- Fee-for-Service Medicare claims are processed by regionally-based Medicare Administrative Contractors (MACs). The MAC for New York State is National Government Services (NGS). NGS is responsible for provider enrollment, fee schedules, establishing Local Coverage Determinations, and claims processing.
- CMS Internet Only Manual (IOM) provides detailed regulations and coverage guidelines of the Medicare program. See Publication 100-1, Chapter 4; Publication 100-2, Chapter 7 and 15; and Publication 100-4, Chapters 1, 11 and 12, http://www.cms.hhs.gov/manuals/
## Appendix A: Standard Framework for Levels of Integrated Healthcare

### Table 1. Six Levels of Collaboration/Integration (Core Descriptions)

<table>
<thead>
<tr>
<th>Level</th>
<th>Collaboration/Integration</th>
<th>Key Element</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1</td>
<td>Basic Collaboration</td>
<td>Key Element: Communication</td>
<td>Behavioral health, primary care and other healthcare providers work:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Have separate systems</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Communicate about cases only rarely and under compelling circumstances</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Communicate, driven by provider need</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>May never meet in person</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Have limited understanding of each other's roles</td>
</tr>
<tr>
<td>Level 2</td>
<td>Basic Collaboration</td>
<td>Key Element: Physical Proximity</td>
<td>Behavioral health, primary care and other healthcare providers work:</td>
</tr>
<tr>
<td></td>
<td>at a Distance</td>
<td></td>
<td>Have separate systems</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Communicate periodically about shared patients</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Communicate, driven by specific patient issues</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>May meet as part of larger community</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Appreciate each other's roles as resources</td>
</tr>
<tr>
<td>Level 3</td>
<td>Basic Collaboration</td>
<td>Key Element: Practice Change</td>
<td>Behavioral health, primary care and other healthcare providers work:</td>
</tr>
<tr>
<td></td>
<td>Onsite</td>
<td></td>
<td>Have separate systems</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Communicate regularly about shared patients, by phone or e-mail</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Collaborate, driven by need for each other's services and more reliable referral</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Meet occasionally to discuss cases due to close proximity</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Feel part of a larger yet ill-defined team</td>
</tr>
<tr>
<td>Level 4</td>
<td>Close Collaboration</td>
<td></td>
<td>Share some systems, like scheduling or medical records</td>
</tr>
<tr>
<td></td>
<td>Onsite with Some System Integration</td>
<td></td>
<td>Communicate in person as needed</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Collaborate, driven by need for consultation and coordinated plans for difficult patients</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Have regular face-to-face interactions about some patients</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Have a basic understanding of roles and culture</td>
</tr>
<tr>
<td>Level 5</td>
<td>Close Collaboration</td>
<td></td>
<td>Actively seek system solutions together or develop work-a-rounds</td>
</tr>
<tr>
<td></td>
<td>Approaching an Integrated Practice</td>
<td></td>
<td>Communicate frequently in person</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Collaborate, driven by desire to be a member of the care team</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Have regular team meetings to discuss overall patient care and specific patient issues</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Have an in-depth understanding of roles and culture</td>
</tr>
<tr>
<td>Level 6</td>
<td>Full Collaboration in a Transformed/Merged Integrated Practice</td>
<td></td>
<td>Have resolved most or all system issues, functioning as one integrated system</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Communicate consistently at the system, team and individual levels</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Collaborate, driven by shared concept of team care</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Have formal and informal meetings to support integrated model of care</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Have roles and cultures that blur or blend</td>
</tr>
</tbody>
</table>
Table 2A. Six Levels of Collaboration/Integration (Key Differentiators)

<table>
<thead>
<tr>
<th></th>
<th>COORDINATED</th>
<th>CO-LOCATED</th>
<th>INTEGRATED</th>
</tr>
</thead>
<tbody>
<tr>
<td>LEVEL 1</td>
<td>Minimal Collaboration</td>
<td>Basic Collaboration at a Distance</td>
<td>Basic Collaboration Onsite</td>
</tr>
<tr>
<td></td>
<td>Screening and assessment done according to separate practice models</td>
<td>Separate treatment plans</td>
<td>Consistent set of agreed upon screenings across disciplines, which guide treatment interventions</td>
</tr>
<tr>
<td></td>
<td>Patient physical and behavioral health needs are treated as separate issues</td>
<td>Patient health needs are treated separately, but records are shared, promoting better provider knowledge</td>
<td>Consistent set of agreed upon screenings across disciplines, which guide treatment interventions</td>
</tr>
<tr>
<td></td>
<td>Patient must negotiate separate practices and sites on their own with varying degrees of success</td>
<td>Patients may be referred, but a variety of barriers prevent many patients from accessing care</td>
<td>Consistent set of agreed upon screenings across disciplines, which guide treatment interventions</td>
</tr>
<tr>
<td>LEVEL 2</td>
<td>Basic Collaboration at a Distance</td>
<td>May agree on a specific screening or other criteria for more effective in-house referral</td>
<td>Collaborative treatment planning for all shared patients</td>
</tr>
<tr>
<td></td>
<td>Screening based on separate practices; information may be shared through formal requests or Health Information Exchanges</td>
<td>Separate service plans with some shared information that informs them</td>
<td>Collaborative treatment planning for all shared patients</td>
</tr>
<tr>
<td></td>
<td>Separate treatment plans shared based on established relationships between specific providers</td>
<td>Some shared knowledge of each other’s EBPs, especially for high utilizers</td>
<td>Some EBPs and some training shared, focused on interest or specific population needs</td>
</tr>
<tr>
<td></td>
<td>Separate responsibility for care/EBPs</td>
<td></td>
<td>Some EBPs and some training shared, focused on interest or specific population needs</td>
</tr>
<tr>
<td>LEVEL 3</td>
<td>Basic Collaboration Onsite</td>
<td>Agree on specific screening, based on ability to respond to results</td>
<td>EBPs shared across system with some joint monitoring of health conditions for some patients</td>
</tr>
<tr>
<td></td>
<td>Close Collaboration Onsite with Some System Integration</td>
<td>Collaborative treatment planning for specific patients</td>
<td>EBPs shared across system with some joint monitoring of health conditions for some patients</td>
</tr>
<tr>
<td></td>
<td>Close proximity allows referrals to be more successful and easier for patients, although who gets referred may vary by provider</td>
<td>Some EBPs and some training shared, focused on interest or specific population needs</td>
<td>EBPs shared across system with some joint monitoring of health conditions for some patients</td>
</tr>
<tr>
<td>LEVEL 4</td>
<td>Close Collaboration Approaching an Integrated Practice</td>
<td>Collaboarative treatment planning for specific patients</td>
<td>EBPs shared across system with some joint monitoring of health conditions for some patients</td>
</tr>
<tr>
<td></td>
<td>Full Collaboration in a Transformed/Merged Integrated Practice</td>
<td>Some EBPs and some training shared, focused on interest or specific population needs</td>
<td>EBPs shared across system with some joint monitoring of health conditions for some patients</td>
</tr>
<tr>
<td></td>
<td>Populatation-based medical and behavioral health screening is standard practice with results available to all and response protocols in place</td>
<td>Consistent set of agreed upon screenings across disciplines, which guide treatment interventions</td>
<td>Population-based medical and behavioral health screening is standard practice with results available to all and response protocols in place</td>
</tr>
<tr>
<td></td>
<td>One treatment plan for all patients</td>
<td>Collaborative treatment planning for all shared patients</td>
<td>One treatment plan for all patients</td>
</tr>
<tr>
<td></td>
<td>EBPs are team selected, trained and implemented across disciplines as standard practice</td>
<td>Collaborative treatment planning for all shared patients</td>
<td>EBPs are team selected, trained and implemented across disciplines as standard practice</td>
</tr>
</tbody>
</table>

Key Differentiator: Clinical Delivery

- Screening and assessment done according to separate practice models
- Separate treatment plans
- Evidenced-based practices (EBP) implemented separately
- May agree on a specific screening or other criteria for more effective in-house referral
- Separate service plans with some shared information that informs them
- Some shared knowledge of each other’s EBPs, especially for high utilizers
- Consistent set of agreed upon screenings across disciplines, which guide treatment interventions
- Population-based medical and behavioral health screening is standard practice with results available to all and response protocols in place

Key Differentiator: Patient Experience

- Patient physical and behavioral health needs are treated as separate issues
- Patient health needs are treated separately, but records are shared, promoting better provider knowledge
- Patients may be referred, but a variety of barriers prevent many patients from accessing care
- Close proximity allows referrals to be more successful and easier for patients, although who gets referred may vary by provider
- Collaborative treatment planning for all shared patients
- Some EBPs and some training shared, focused on interest or specific population needs
- One treatment plan for all patients
- EBPs are team selected, trained and implemented across disciplines as standard practice
- Patients experience a seamless response to all healthcare needs as they present, in a unified practice
Table 2B. Six Levels of Collaboration/Integration (Key Differentiators, continued)

<table>
<thead>
<tr>
<th>COORDINATED</th>
<th>CO-LOCATED</th>
<th>INTEGRATED</th>
</tr>
</thead>
<tbody>
<tr>
<td>LEVEL 1</td>
<td>LEVEL 2</td>
<td>LEVEL 3</td>
</tr>
<tr>
<td>Minimal Collaboration</td>
<td>Basic Collaboration at a Distance</td>
<td>Basic Collaboration Onsite</td>
</tr>
<tr>
<td>LEVEL 4</td>
<td>LEVEL 5</td>
<td>LEVEL 6</td>
</tr>
<tr>
<td>Close Collaboration Onsite with Some System Integration</td>
<td>Close Collaboration Approaching an Integrated Practice</td>
<td>Full Collaboration in a Transformed/ Merged Integrated Practice</td>
</tr>
</tbody>
</table>

**Key Differentiator: Practice/Organization**

- No coordination or management of collaborative efforts
- Little provider buy-in to integration or even collaboration, up to individual providers to initiate as time and practice limits allow
- Some practice leadership in more systematic information sharing
- Some provider buy-in to collaboration and value placed on having needed information
- Organization leaders supportive but often colocation is viewed as a project or program
- Provider buy-in to making referrals work and appreciation of onsite availability
- Organization leaders support integration through mutual problem-solving of some system barriers
- More buy-in to concept of integration but not consistent across providers, not all providers using opportunities for integration or components
- Organization leaders support integration, if funding allows and efforts placed in solving as many system issues as possible, without changing fundamentally how disciplines are practiced
- Nearly all providers engaged in integrated model. Buy-in may not include change in practice strategy for individual providers
- Organization leaders strongly support integration as practice model with expected change in service delivery, and resources provided for development
- Integrated care and all components embraced by all providers and active involvement in practice change

**Key Differentiator: Business Model**

- Separate funding
- No sharing of resources
- Separate billing practices
- Separate funding
- May share resources for single projects
- Separate billing practices
- Separate funding
- May share facility expenses
- Separate billing practices
- Separate funding, but may share grants
- May share office expenses, staffing costs, or infrastructure
- Separate billing due to system barriers
- Blended funding based on contracts, grants or agreements
- Variety of ways to structure the sharing of all expenses
- Billing function combined or agreed upon process
- Integrated funding, based on multiple sources of revenue
- Resources shared and allocated across whole practice
- Billing maximized for integrated model and single billing structure
### Table 3. Advantages and Weaknesses at Each Level of Collaboration/Integration

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
<th>Advantages</th>
<th>Weaknesses</th>
</tr>
</thead>
<tbody>
<tr>
<td>LEVEL 1</td>
<td>Minimal Collaboration</td>
<td></td>
<td></td>
</tr>
<tr>
<td>LEVEL 2</td>
<td>Basic Collaboration at a Distance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>LEVEL 3</td>
<td>Basic Collaboration Onsite</td>
<td></td>
<td></td>
</tr>
<tr>
<td>LEVEL 4</td>
<td>Close Collaboration Onsite with Some System Integration</td>
<td></td>
<td></td>
</tr>
<tr>
<td>LEVEL 5</td>
<td>Close Collaboration Approaching an Integrated Practice</td>
<td></td>
<td></td>
</tr>
<tr>
<td>LEVEL 6</td>
<td>Full Collaboration in a Transformed/ Merged Integrated Practice</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Advantages

- Each practice can make timely and autonomous decisions about care
- Readily understood as a practice model by patients and providers
- Maintains each practice’s basic operating structure, so change is not a disruptive factor
- Provides some coordination and information-sharing that is helpful to both patients and providers
- Colocation allows for more direct interaction and communication among professionals to impact patient care
- Referrals more successful due to proximity
- Opportunity to develop closer professional relationships
- Removal of some system barriers, like separate records, allows closer collaboration to occur
- Both behavioral health and medical providers can become more well-informed about what each can provide
- Patients are viewed as shared which facilitates more complete treatment plans
- High level of collaboration leads to more responsive patient care, increasing engagement and adherence to treatment plans
- Provider flexibility increases as system issues and barriers are resolved
- Both provider and patient satisfaction may increase
- Opportunity to truly treat whole person
- All or almost all system barriers resolved, allowing providers to practice as high functioning team
- All patient needs addressed as they occur
- Shared knowledge base of providers increases and allows each professional to respond more broadly and adequately to any issue

#### Weaknesses

- Patient physical and behavioral health needs are treated as separate issues
- Patient must negotiate separate practices and sites on their own with varying degrees of success
- Patient health needs are treated separately, but records are shared, promoting better provider knowledge
- Proximity may not lead to greater collaboration, limiting value
- Effort is required to develop relationships
- Limited flexibility, if traditional roles are maintained
- System issues may limit collaboration
- Potential for tension and conflicting agendas among providers as practice boundaries loosen
- Practice changes may create lack of fit for some established providers
- Time is needed to collaborate at this high level and may affect practice productivity or cadence of care
- Sustainability issues may stress the practice
- Few models at this level with enough experience to support value
- Outcome expectations not yet established
Appendix B: Licensure of Clinics and Individual Practitioners

There are many types of licensure in New York State relevant to behavioral health and primary care integration. These types are broadly categorized into “clinic” and “individual practitioner,” and the importance of the different licenses depends on the payer and their reimbursement policies.

CLINIC LICENSURE:

There are multiple kinds of clinic licensure in New York State, all but one of which is important to Medicaid, only one of which is recognized by Medicare, and some of which hold importance to other payers.

Article 28 Clinic: also known as a “Diagnostic and Treatment Center”:

- An Article 28 clinic is “a medical facility with one or more organized health services not part of an inpatient hospital facility or vocational rehabilitation center primarily engaged in providing services and facilities to out-of-hospital or ambulatory patients by or under the supervision of a physician... for the prevention, diagnosis and, in the case of a treatment center, treatment of human disease, pain, injury, deformity or physical condition, not including the individual or group private practice of medicine.”

- Further defined in Title 14 Part 599 as “an outpatient program licensed as a diagnostic and treatment center pursuant to article 28 of the Public Health Law which provides more than 10,000 mental health visits annually, or for which mental health visits comprise over 30 percent of the annual visits. A program providing fewer than 2,000 total visits annually shall not be required to be licensed by the Office.”

- Regulated by the New York State Department of Health

- Primarily a provider of physical healthcare services

- Mental health services may be provided by individuals licensed as certified social workers, physicians, psychologists, and registered professional nurses provided a written care plan and results of treatment are reviewed at least every 30 days by the physician and appropriate professional staff.

- Recognized by New York State Medicaid as a provider category

- Not recognized by Medicare as a provider category

Article 28 “Extension Clinic”:

- Extension clinic shall mean a clinic which is a component of a general hospital sponsored ambulatory care program, or a diagnostic and treatment center sponsored ambulatory care program, offering services of a non-emergent nature and located on premises other than those of the hospital or diagnostic and treatment center which operates it. An extension clinic of a hospital or diagnostic and treatment center may be certified to provide services, authorized to be provided by a diagnostic and treatment center, other than or in addition to the services provided at the sponsoring hospital or center. Extension clinics are required to have separate operating certificates for each site, indicating specific services approved to be provided at that site.

---

9. 10 NYCRR Article 6, Section 751.1, Treatment Center and Diagnostic Center Operation. Accessed at http://w3.health.state.ny.us/dbspace/NYCRR10.nsf/56cf2e25d626f9785256538006c3ed7757f15c84a188458525687004dc6f8?OpenDocument&Highlight=0,diagnostic
11. 10 NYCRR Article 6, Section 752-1.1
Regulated by the Department of Health
Recognized by New York State Medicaid as a provider category
Not recognized by Medicare as a provider category

Article 28 “Part-time Clinic”:
Definition: “Part-time clinic site shall mean an ambulatory care program site operated less than 60 hours per month (as determined by the aggregate hours of program site operation) by a general hospital or a diagnostic or treatment center which is approved to operate part-time clinics. A part-time clinic site is a site other than the primary delivery site(s) listed on the primary facility’s operating certificate; provided, however, that any health care services provided in elementary or secondary schools to students during regular school hours shall not qualify as part-time clinic sites under this Title.”

Intended for limited and low-risk procedures and examinations; not intended for follow up care
Recognized by New York State Medicaid as a provider category
Not recognized by Medicaid as a provider category

Article 28 “Federally Qualified Health Center”:
Federally qualified health centers (FQHCs) include all organizations receiving grants under Section 330 of the Public Health Service Act (PHS). FQHCs qualify for enhanced reimbursement from Medicare and Medicaid, as well as other benefits. FQHCs must serve an underserved area or population, offer a sliding fee scale, provide comprehensive services, have an ongoing quality assurance program, and have a governing board of directors. Certain tribal organizations and FQHC Look-Alikes (an organization that meets PHS Section 330 eligibility requirements, but does not receive grant funding) also may receive special Medicare and Medicaid reimbursement

Regulated by the federal Health Resources and Services Administration (HRSA); licensed by Office of Mental Health
Recognized by New York State Medicaid as a provider category
Is recognized by Medicare as a provider category

Article 31 Clinic:
Clinic treatment program -- A program licensed under Article 31 of the Mental Hygiene Law for adults, adolescents, and/or children which provides an array of treatment services for assessment and/or symptom reduction or management. Services include but are not limited to individual and group therapies. The purpose of such services is to enhance the person’s continuing functioning in the community. The intensity of services and number/duration of visits may vary.

12. 10 NYCRR, Section 401.1 accessed at http://w3.health.state.ny.us/dbspace/NYCRR10.nsf?56cf2e25d626f9f785256538006c3ed7/8525652c00680c3e8525652c0063482fOpenDocument&Highlight=0,extension,clinic
13. Medicare mostly enrolls specific types of practitioners, either individually or as a group. See [insert URL] for the full list of Medicare provider enrollment categories.
Regulated by the New York State Office of Mental Health

Primarily a provider of mental health services

Physical healthcare services may be provided when [insert limitations, including operating certificate requirement]

Recognized by New York State Medicaid as a provider category

Not recognized by Medicare as a provider category

**Article 31 “Satellite Clinic”:**

- Satellite means a physically separate adjunct site to a certified clinic treatment program, which provides either a full or partial array of outpatient services on a regularly and routinely scheduled basis (full or part time) \(^{16}\)

- Requires an explicit clinical and administrative linkage between the satellite and the primary program which includes, but is not limited to, methods of staff supervision, treatment planning, review of treatment plans, maintenance of the records of individuals receiving services, and utilization review.

- Regulated and approved by the Office of Mental Health

- Recognized by New York State Medicaid as a provider category

- Not recognized by Medicare as a provider category

**INDIVIDUAL PRACTITIONER LICENSURE**

Physicians, psychiatrists, clinical psychologists, clinical social workers, clinical nurse specialists, nurse practitioners and physician assistants are recognized by Medicare B to provide diagnostic and therapeutic treatment for mental, psycho-neurotic and personality disorders. Independent Psychologists/Non-Clinical Psychologists are recognized by Medicare Part B for diagnostic services only. Coverage is limited to those services that the mental health professional is legally authorized to perform under State law (or the State regulatory mechanism provided by State law) of the state in which such services are performed for the diagnosis and treatment of mental illnesses. \(^{17}\)

Individual practitioners are regulated by State Scope of Practice laws. While Medicare has definitions for individual practitioners and services that are covered, it ultimately defers to State Scope of Practice laws to regulate what can and cannot be provided by a particular health care professional.

- Physicians - Psychiatrists
- Nurse Practitioner (NP), including Psychiatric Nurse Practitioner
- Physician Assistant (PA)
- Clinical Psychologist (CP)
- Clinical Social Worker (CSW)
- Clinical Nurse Specialist (CNS); Registered Nurse

---


Medicare reimburses for services and supplies provided “incident to” a physicians’ or other practitioners (defined as physician, PA, NP, CNS or CP) -- that is, provided as an integral part of the physician’s personal services with respect to diagnosis or treatment. Services must be performed by the physician or (if by auxiliary personnel other than a PA, NP, CNS or CP) under direct supervision of the physician, which means that the physician must be present in the office and immediately available to provide assistance and direction.\(^\text{18}\)

\(^{18}\) Note: pharmacological management services cannot be performed under “incident to” provision.
# Appendix C: Required and Optional Article 31 Service Definitions and Guidance

## Required Article 31 Service Definitions and Guidance

<table>
<thead>
<tr>
<th>DEFINITION</th>
<th>GUIDANCE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Initial Assessment:</strong> 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 diagnosis, and the development of a treatment plan for such recipient.</td>
<td>The Initial Assessment requires an assurance that a health screening has been done and is documented in the recipient's record. Health screening documentation may be provided by the recipient, or it can be obtained from other sources, such as the recipient's primary care physician, where appropriate. Health information should be reviewed by a Psychiatrist, nurse practitioner in psychiatry (NPP), or other appropriate health care professional. Initial Assessments may be provided pre and post admission. Assessment information collected must be used to determine admission to the clinic level of treatment (or other disposition).</td>
</tr>
<tr>
<td><strong>Psychiatric Assessment:</strong> A “psychiatric assessment” is an interview with an adult or child or his or her family member or other collateral, performed by a psychiatrist or nurse practitioner in psychiatry, or physician assistant with specialized training approved by the Office. A psychiatric assessment may occur at any time during the course of treatment, for the purposes of diagnosis, treatment planning, medication therapy, and/or consideration of general health issues.</td>
<td>A significant difference between a psychiatric assessment and psychiatric consultation is that the former is provided to an individual who has been admitted to the clinic or for whom admission is anticipated. The latter is delivered upon referral from another physician to an individual not currently admitted to the clinic. A report must be transmitted to the referring provider. The Medicaid fee-for-service reimbursements are identical.</td>
</tr>
<tr>
<td><strong>Psychotherapy (individual, family/collateral, group):</strong> Psychotherapy 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.</td>
<td>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.</td>
</tr>
<tr>
<td><strong>Psychotropic Medication Treatment:</strong> Psychotropic medication treatment means monitoring and evaluating target symptom response, ordering and reviewing diagnostic studies, writing prescriptions and consumer education as appropriate.</td>
<td>This service must be provided by a psychiatrist or nurse practitioner in psychiatry (NPP).</td>
</tr>
<tr>
<td><strong>Injectable Psychotropic Medication Administration for Clinics Serving Adults (administration, education/monitoring):</strong> Injectable psychotropic medication administration is the process of preparing, and administering the injection of intramuscular psychotropic medications. Injectable Psychotropic Medication Administration with monitoring and education is the process of preparing, administering, managing and monitoring the injection of intramuscular psychotropic medications. It includes consumer education related to the use of the medication, as necessary. This service is optional for clinics serving only children.</td>
<td>This service must be provided by an appropriate medical staff person as shown in the staffing eligibility table in the OMH Part 599 Interpretive/Implementation Guidance.</td>
</tr>
</tbody>
</table>
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.

Complex Care Management: 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. It must be provided as an ancillary service to a crisis service or a face-to-face psychotherapy service. For Medicaid fee-for-service reimbursement, it must take place within 5 working days following the provision of either service. Complex Care does not include required and routine paperwork or required and routine follow up.

The need for the Complex Care and the persons contacted must be documented in the progress note. While Complex Care 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. However, if Complex Care is performed by a different therapist, the activities must be coordinated with the treating therapist and documented in the client’s progress note.

Optional Article 31 Service Definitions and Guidance

**DEFINITION**

**Developmental Testing:** Developmental testing is the administration, interpretation, and reporting of screening and assessment instruments for children or adolescents to assist in the determination of the individual’s developmental level for the purpose of facilitating the mental health diagnosis and treatment planning processes.

**Psychological Testing:** Psychological testing is a psychological evaluation using standard assessment methods and instruments to assist in mental health assessment and the treatment planning processes.

**Psychiatric Consultation:** Psychiatric consultation means a face-to-face evaluation, which may be in the form of video telepsychiatry, of a consumer by a psychiatrist or nurse practitioner in psychiatry, including the preparation, evaluation, report or interaction between the psychiatrist or nurse practitioner in psychiatry and another referring physician for the purposes of diagnosis, integration of treatment and continuity of care.

**GUIDANCE**

Developmental testing may only be offered to individuals admitted to the clinic. This service must be provided by an appropriate staff person as shown in the staffing eligibility table in the OMH Part 599 Interpretive/Implementation Guidance.

Psychological testing must be provided by a licensed doctor of psychology and can only be provided to individuals admitted to the clinic.

This service is intended to support primary care doctors in their treatment of individuals with mental illness. Consultation services can support:

1. The treatment of mental illness in primary care settings; or
2. The transition from clinic based mental health care to primary care mental health treatment.

A written report must be provided by the consulting physician or nurse practitioner to the referring physician.
**Health Physicals:** A health physical is the physical evaluation of an individual, including an age and gender appropriate history, examination, and the ordering of laboratory/diagnostic procedures as appropriate.

This service must be provided by a physician, nurse practitioner or other medical professional acting within scope of practice. The clinic must have a policy in place for ascertaining this information as part of the initial assessment or when otherwise required.

**Health Monitoring:** Health monitoring is the continued measuring of specific health indicators associated with increased risk of medical illness and early death. For adults, these indicators include, but are not limited to, blood pressure, body mass index (BMI), substance use and smoking cessation. For children and adolescents, these indicators include, but are not limited to, BMI percentile, activity/exercise level, and smoking status.

This service must be provided by a physician, nurse or other medical professional acting within scope of practice. Section 599.6 requires that a provider have policies and procedures for age appropriate health monitoring, which describe whether such monitoring will be performed by the provider or, if not, how the provider will seek to ascertain relevant health information. Such policies and procedures must include a requirement that an individual’s refusal to provide access to such information be documented in the case record.

---

**Appendix D: Practitioner Reimbursement Under Medicaid Part 599 and Medicare Part B**

<table>
<thead>
<tr>
<th>Service</th>
<th>MD</th>
<th>PA</th>
<th>NP</th>
<th>NPP</th>
<th>RN</th>
<th>LCSW</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Physicals</td>
<td>Both</td>
<td>Both</td>
<td>Both</td>
<td>Both</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Health Monitoring</td>
<td>Both</td>
<td>Both</td>
<td>Both</td>
<td>Both</td>
<td>Both*</td>
<td>No</td>
</tr>
<tr>
<td>Smoking Cessation</td>
<td>Both</td>
<td>Both</td>
<td>Both</td>
<td>Both</td>
<td>Both*</td>
<td>Medicare only</td>
</tr>
<tr>
<td>Complex Care Management</td>
<td>599 only</td>
<td>No</td>
<td>599 only</td>
<td>599 only</td>
<td>599 only</td>
<td>599 only</td>
</tr>
<tr>
<td>Injectable Psych Rx Admin.</td>
<td>Both</td>
<td>Both</td>
<td>Both</td>
<td>Both</td>
<td>Both*</td>
<td>No</td>
</tr>
</tbody>
</table>

*Denotes reimbursable Under 599 and Medicare reimbursable as incident-to Evaluation and Management.*
Appendix E: Article 28 Extension and Part-Time Clinics

Your standard health clinic (a “diagnostic and treatment center” (D&TC) or “hospital extension clinic”) is defined as follows:

The terms treatment center and diagnostic center shall mean a medical facility with one or more organized health services not part of an inpatient hospital facility or vocational rehabilitation center primarily engaged in providing services and facilities to out-of-hospital or ambulatory patients by or under the supervision of a physician or, in the case of a dental service or dispensary, of a dentist, for the prevention, diagnosis and, in the case of a treatment center, treatment of human disease, pain, injury, deformity or physical condition, not including the individual or group private practice of medicine.

Additional guidance regarding D&TC/Extension clinics is available through the Department of Health.

A “part-time clinic” is defined in Title 10 as follows:

Part-time clinic site shall mean an ambulatory care program site operated less than 60 hours per month (as determined by the aggregate hours of program site operation) by a general hospital or a diagnostic or treatment center which is approved to operate part-time clinics. A part-time clinic site is a site other than the primary delivery site(s) listed on the primary facility’s operating certificate; provided, however, that any health care services provided in elementary or secondary schools to students during regular school hours shall not qualify as part-time clinic sites under this Title.

Additional guidance regarding Part-Time clinics is available through the Department of Health.
Appendix F: Medicare Part B

The best summary of federal guidance for each category of provider is the “MLN Guided Pathways to Medicare Resources.” This booklet has a section for each category of provider and includes required education and certification, benefits covered by types of providers, and claims processing.

Among Medicare Part B Approved Providers are:

- Physicians
- Advanced Practice Nurses (including Clinical Nurse Specialists and Nurse Practitioners)
  - National board certification is required for Medicare and Medicaid credentialing (e.g., through American Nurses Credentialing Center ANCC certification www.nursecredentialing.org/certification.aspx)
  - State licensure to practice
- Physician Assistants
- Clinical Social Workers
- Psychologists (clinical and independently practicing)

Note: Community Mental Health Centers are also eligible providers under Medicare, but they are recognized as providers only for partial hospitalization services that are prescribed by and furnished under supervision of a physician. A Community Mental Health Center may also have individual practitioners enrolled as outlined above.

Services provided by other practitioners, including those listed above, can be reimbursed when provided “Incident-To” a physician’s service.

Medicare covers a range of both physical and behavioral healthcare services that are medically necessary to diagnose and treat a medical condition as well as preventive services. A full listing of services can be found at www.medicare.gov/what-medicare-covers/part-b, but behavioral health services include:

- Depression screenings, once per year. The screening must be done in a primary care setting that can provide follow-up treatment and/or referrals.
- Tobacco use cessation counseling.
- Outpatient mental health services provided by a physician, clinical psychologist, clinical social worker, nurse practitioner, clinical nurse specialist, certified nurse-midwife or physician assistant who accepts Medicare payment.

20. 42 CFR Chapter IV, Subchapter B, Section 410.110 and 410.172.

ASSIGNING PAYMENT

Q: If our practitioner enrolls directly into Medicare, will their payments go to the individual practitioner or to our agency?

A: When enrolling, the practitioner can designate your agency as the receiver of payments.