Integrated Mental Health, Substance Use and Primary Medical Care:
Barriers and Opportunities (March 2024)

For over a decade, New York State (NYS) elected and appointed officials have supported integrated outpatient mental health, substance use and primary medical care, especially for NYS-licensed outpatient programs that disproportionately serve people of color, low-income residents, and people with serious behavioral health (mental health and substance use) conditions. Under the DSRIP Medicaid Waiver Program (2015-2020), integrated outpatient care was a key priority because coordinated and accessible community services were viewed as critical to achieving better population health outcomes, while reducing preventable inpatient and emergency episodes.

At the time, the benefits of an Integrated Outpatient Services (IOS) license were compelling. The IOS license would: (1) Expand the availability of behavioral health and primary care services by allowing providers to deliver a range of cross-agency clinic services at a single site under a single license; (2) Promote coordination of care for individuals receiving services with an integrated Electronic Medical Record; (3) Reduce administrative burden with a single State oversight agency and recertification survey; and (4) Eliminate the 10% discount for multiple behavioral health services in the same day.

Unfortunately, NYS Office of Mental Health (OMH), Office of Addiction Services and Supports (OASAS) and Department of Health (DOH) current regulations and guidance, including those related to IOS licensure, have created a confusing and unnecessarily complicated environment for NYS community providers that want to offer integrated care. It is challenging for the delivery of behavioral health care, where agencies are seeking IOS licenses. The regulations for Article 32 Outpatient Addiction Treatment Programs, Article 31 Mental Health Programs and IOS Programs differ in many aspects of service delivery and operating requirements discussed below (e.g., assessment, treatment planning, progress notes, service definitions such as Complex Care management, etc.). The lack of alignment makes it extraordinarily complicated to provide mental health and addiction treatment at one location, while complying with three different sets of rules.

Community agencies with DOH-licensed Diagnostic and Treatment Centers (DTC) also encounter regulatory barriers that have largely discouraged them from applying for an IOS license. Instead, some agencies have co-located DTC and OMH and/or OASAS-licensed outpatient programs in the same building to provide patients with easy access to services, though agencies maintain distinct program boundaries (i.e., clinical records, billing, staffing, etc.).

It is not an exaggeration to say that the lack of alignment among the outpatient systems of care has created a crushing administrative burden for thinly resourced community providers that are trying to implement NYS's integrated care vision, which is also the best practice for delivering outpatient services. They also each struggle to secure regulatory waivers to address a problem that would be better addressed systemically. An example of the "waiver fix" is illustrated by the following Part 825 IOS regulatory guidance that was issued after OASAS's 2021 adoption of revised Part 822 regulations for outpatient treatment programs. The 2021 Part 822 regulations made substantial changes to the treatment planning requirements for OASAS-certified outpatient programs: "Until such time as Part 825 is amended to incorporate the guidance for 822 treatment planning effective 8/2/21, Providers will be required to submit the Request for Waiver from OASAS Regulations (PAS-10) application as well as (1) their updated agency policies and procedures, (2) an agency implementation plan to address staff training on the new regulatory requirements and (3) a timeline for implementation. OASAS states that they are unable to conduct a recertification review of the Integrated Outpatient Service until the 825 waiver is submitted and approved."

Adding to the confusion, NYS is in the process of tripling the number of OASAS and OMH licensed outpatient programs that are in the NYS Certified Community Behavioral Health Clinic (CCBHC) Demonstration Program. Thirteen newly selected sites must obtain IOS licenses before July 1, 2024. To address aspects of the regulatory misalignment, NYS OMH/OASAS is granting waivers to the CCBHC programs. The waivers are not generally available to the wider provider sector.

NYS needs to act in 2024 to simplify this regulatory quagmire to allow providers to more efficiently and effectively treat patients experiencing mental illness and substance use disorder (SUD). To advance this work, The Partnership for Integrated Care (InUnity Alliance and NYS

Council for Community Behavioral Healthcare), supported by a grant from the New York Community Trust, undertook a review of the regulatory environment. Leaders from community organizations throughout NYS that are licensed by OMH, OASAS and/or DOH to deliver outpatient services were interviewed to understand the challenges of providing integrated care within this current environment.

Described below are four significant, straight-forward changes that the Partnership recommends NYS implement in 2024 to foster delivery of integrated outpatient services throughout NYS, while reducing the administrative burden now imposed on organizations seeking to provide integrated care.

1) Align OMH, OASAS and IOS Licensure Regulations, the Medicaid Reimbursement Framework and the Oversight Agencies' Guidelines for Outpatient Mental Health and Substance Use Services with a No Wrong Door Approach. In September 2023, OASAS posted an IOS FAQ to clarify the operational confusion, which said the following, "Only those with both an addiction and mental health-related disorder should be admitted into the IOS Program. Those with addiction only should be admitted into the Article 32 Outpatient Addiction Treatment program; and those with mental health only should be admitted into the Article 31 OMH Outpatient Program." This guidance is still in effect. Today, all CCBHCs and the many other behavioral health agencies have co-located Article 32 and 31 outpatient programs. Many also have IOS licenses for the same locations. According to the OASAS FAQ, providers must serve clients on three tracks with three different programmatic standards and reimbursement frameworks for delivering mental health and substance use services.

This three-track approach makes little sense when we have known for a long time about the prevalence of co-occurring mental health conditions and substance use disorders (SUDs). According to NIH's National Institute on Drug Abuse: "Many individuals who develop SUD are also diagnosed with mental disorders, and vice versa. Multiple national population surveys have found that about half of those who experience a mental illness during their lives will also experience a SUD and vice versa. Although there are fewer studies on comorbidity among youth, research suggests that adolescents with SUDs also have high rates of co-occurring mental illness; over 60% of adolescents in community-based SUD treatment programs also

meet diagnostic criteria for another mental illness."[1] SAMHSA's latest survey, the 2022 National Survey on Drug Use and Health, found that about half (52.9%) of adults aged 18 or older with a serious mental illness (SMI) and 43.9% of adults with any mental illness used illicit drugs in the past year, compared with 20.6% of adults aged 18 or older with no mental illness.[2]

In September 2023, OMH and OASAS released their vision statement for a three-pronged approach to integrated care, with enhanced, capable, and minimum standards for offering care, which does not directly address the lack of alignment of the current three-track IOS, mental health and SUD regulatory environment.

Recommendation: IOS licensure should indicate provider competencies to serve all three populations. OMH and OASAS should update the IOS regulations to enable providers to serve individuals with mental health only, substance use only and both conditions at outpatient programs with IOS licensure. The reimbursement framework for IOS programs should be inclusive of billing for all mental health and substance use services provided at the IOS outpatient program. The regulations should reflect that all aspects of service delivery, such as assessment/treatment planning requirements, service definitions, documentation and billing are uniform regardless of a person's diagnosis. These changes would dramatically reduce the current regulatory complexity and administrative burden. A related issue is the lack of integration from a budgetary standpoint. Since staff will be working with clients in all 3 tracks, agencies are challenged to accurately align staffing/expenses with the respective budget.

For programs that do not choose to pursue an IOS license, the Partnership supports implementation of OMH and OASAS regulations for providing services, including integrated service delivery, that align analogous functions so that the administrative burden of operating co-located outpatient programs is greatly reduced. If OMH and OASAS align their regulations to be as consistent as possible, New Yorkers would be able to fluidly receive mental health and/or substance use services at a single program site without extraordinary complexity for the

[1] Common Comorbidities with Substance Use Disorders Research Report. Bethesda (MD): National Institutes on Drug Abuse (US); 2020 Apr. Available from: https://www.ncbi.nlm.nih.gov/books/NBK571451/

[2] Key Substance Use and Mental Health Indicators in the United States: Results from the 2022 National Survey on Drug Use and Health. Rockville (MD): Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration (US); 2023. Available from: https://www.samhsa.gov/data/sites/default/files/reports/rpt42731/2022-nsduh-nnr.pdf

provider and the consumer, which would be a win-win for all New Yorkers. Our providers also believe that this change would further reduce stigma among help-seeking clients, which can still be an unsurmountable impediment to engagement in treatment.

2) Permit OMH and OASAS outpatient providers to offer harm reduction, prevention, rehabilitation, support, and treatment services on the initial visit to address urgent needs, prevent potential crises, reduce health risks, and engage people in services. Today, any New Yorker can visit a NYS-licensed outpatient medical program for the first time and receive needed medical care, from a flu shot to vital signs screening to diagnosis and treatment forhigh blood pressure. There are no barriers to offering prevention services and treatment for routine and urgent conditions on the first visit. The patient will likely then be scheduled for a variety of age, gender, and other appropriate screenings/diagnostic tests (e.g., mammogram, blood work, specialist visits) to identify other issues and/or more accurately assess presenting conditions that might need to be addressed in future visits. Unfortunately, the regulatory frameworks for OMH and OASAS outpatient programs are much more restrictive concerning timely access to needed care.

OMH and OASAS regulations and guidance are not clear about what services can be offered prior to enrollment. Providers interviewed reported that OMH is the most restrictive, requiring a comprehensive intake process (screening, assessment, psychiatric evaluation, diagnosis and treatment planning) before an individual can be admitted as a client for treatment. MHOTRS regulations do not specify the services that can be offered pre-enrollment, however, providers interviewed understand that MHOTRS can only provide crisis care before the admission process is completed. They understand that OASAS regulations are somewhat more flexible, but still somewhat vague. OASAS regulations specify that “services prior to admission” are “the first step in developing a treatment/recovery plan, focusing on issues that need to be addressed to ensure successful engagement and admission into treatment and any other urgent or emergent issues...Services which may be delivered preadmission will be identified by the Office.” From interviews with OASAS-certified outpatient providers, we understand that services OASAS supports pre-admission include medication assisted treatment and harm reduction services. IOS regulations dictate that the host agency requirements govern.

Every day, New Yorkers have urgent issues related to their mental health and/or substance use that could be addressed by OMH and OASAS-licensed outpatient providers to reduce harm

and/or promote recovery. For issues that are not immediately life threatening and can be appropriately addressed in an outpatient setting, we should be encouraging people to seek help from NYS-licensed community-based programs. In fact, some outpatient programs may choose to function as urgent care centers if the regulations allowed them to operate as, and be compensated for, walk-in urgent care.

Unfortunately, people may be deterred from continuing with a mental health or addiction treatment provider if treatment services are delayed until after multiple intake visits. Also, the provider may feel compelled to refer individuals who present with time-sensitive service needs on their initial visit to emergency rooms because the person might be harmed waiting for days or weeks to go through the OMH and OASAS required intake processes.

Recommendation: With most NYS emergency rooms, CPEPs and psychiatric inpatient units strained beyond their capacity, the Partnership urges OMH and OASAS to adopt the DOH approach, where urgent care, routine treatment and harm reduction can be offered on the first visit and during the admissions process. While OMH and OASAS can still set a timeframe for completing an assessment and treatment plan, we advocate for no limits to "pre-admission visits" so that the OMH and OASAS outpatient program can address the person's needs immediately, which will likely improve both admission rates and engagement in services.

We further recommend that the admissions process (screening/assessment/psychiatric evaluation/diagnosis/treatment plan) should be the same for outpatient programs licensed by OMH and OASAS, including those with an IOS license. There is a strong rationale for this position. An outpatient program with only an OMH MHOTRS license may be treating individuals with co-occurring mental health and substance use disorders, and the same can be said for an OASAS-licensed outpatient program. A program with an IOS license will, by definition, only be treating individuals with both conditions. Therefore, the admissions process should be the same.

3) Implement the 2023 legislative change to increase medical services at OMH and OASAS outpatient programs by a licensed health professional (medical doctor, nurse practitioner, physician assistant) from 5% to 30% of total services, with reimbursement comparable to a DOH medical clinic. Individuals experiencing a SMI and/or SUD are at high risk for medical co-morbidities, are less likely to be engaged with a primary care provider (PCP), and wouldbenefit

from easier access to primary care. Those experiencing "SMI, including schizophrenia, major depression and bipolar disorders, have a reduced life expectancy compared to the general population of up to 10–25 years. This high mortality rate is not due to the mental illness, but rather is a consequence of comorbid physical health problems, such as cardiovascular, respiratory, metabolic, infectious diseases and cancer…Additionally, people with SMI are at higher risk of developing obesity and metabolic syndrome (40-70% for those with schizophrenia and 20–30% for those with bipolar disorders), than the general population due to the medications they take to treat their mental health conditions."[3] Substance users are also at higher risk for Hepatitis, HIV and other medical conditions, where timely medical interventions can reduce harm and improve health outcomes.

Making primary care available at behavioral health outpatient programs has the potential to dramatically improve access to, and engagement with, medical care. This change would improve population health and the medical HEDIS quality measures, which are lower for our patient population. Many individuals experiencing SMI and/or SUD are not engaged with PCPs in their communities. PSYCKES showed that in a recent 12-month period, 10% of individuals who received Medicaid-funded mental health and/or substance use services did not have any medical outpatient visits during the year, and an even larger percentage are not regularly engaged with a PCP to manage their health needs. From experience, we know that behavioral health consumers often do not follow-up with referrals to external medical providers. The best on-ramp to any health service is to offer it down the hall from their psychiatrist, therapist and/or counselor.

Starting in the spring of 2024, NYS could have expanded access to medical services at behavioral health outpatient programs. In FY 2024, NYS had authority to expand the licensure threshold to 30% of physical health, mental health and substance use disorder services without obtaining a license from the regulatory agency, however, it has not revised the regulatory and reimbursement framework. When this change is made, it will impact all NYS-licensed outpatient programs (Article 28 DTCs, Article 31 MHOTRS and Article 32 Clinics and Opioid Treatment Programs). While not all behavioral health programs will choose to offer integrated primary care, those that can should be provided every encouragement to do so.

[3] Fiorillo and Sartorius, Annals of General Psychiatry (2021) 20:52, https://doi.org/10.1186/s12991-021-00374-y

Recommendation: OMH and OASAS outpatient programs should have the option to provide medical services to their patients at a level that is financially sustainable (up to 30% of services not the current 5%), and be paid the same rate as a DOH-licensed outpatient medical program (DTC) for the same services. CCBHCs already must provide health screening and monitoring, so many community-based OMH and OASAS programs will be building their health services capacity in the next few years. Regulations and reimbursement should support the addition of primary care in behavioral health outpatient programs for clients who are not engaged with an external medical provider or prefer their primary care available at their behavioral health provider.

4) Align OMH, OASAS and IOS outpatient regulations so that service definition, operational and staffing standards are the same. Today, there are multiple inconsistencies between OMH/OASAS/IOS regulations. For example, the service Complex Care Management (CCM) in an OASAS program can be billed in 5-minute units up to 4 units (20 minutes) per day *with no precipitating event required*. For OMH clinics, CCM is billed in maximum of four units of at least five consecutive minutes of CCM *within 14 calendar days of required precipitating events*. For IOS, the host agency requirements prevail.

There are similar inconsistencies throughout the OMH, OASAS and IOS regulations and operational guidance.

- Providers interviewed report that OMH requires four and OASAS requires eight consent forms to be completed, though both treat people with mental health and substance use disorders. There are more for OASAS than OMH due to certain requirements (e.g., tobacco-free environment, criminal justice client, LOCADTR, Justice Center fingerprinting).
- OMH requires that treatment plans with medication be signed by a psychiatrist, NPP or MD, and those without medication can be signed additionally by any licensed practitioner, while OASAS allows them to be signed by "a single member of the clinical staff responsible for coordinating and managing the patient's treatment." IOS regulations allow signature by "the qualified health professional, or other licensed individual."
- OMH allows any licensed professional to sign an admission note, while OASAS requires a qualified health professional's signature and approval by a "physician, physician's assistant, nurse practitioner, licensed psychologist, or licensed clinical social worker."

- IOS regulations require the Medical Director to be a licensed physician Board certified in addiction treatment with a federal waiver, but OASAS regulations require the Medical Director to be a licensed physician with "at least one year of education, training, and/or experience in substance use disorder services."

One difference that can impact agencies financially and creates an unnecessary administrative burden is the billing requirements. OMH shared new billing guidance in August 2023, where they adopted AMA minimum timeframes for CPT codes. When any clinical services with an APG rate in an OMH clinic (e.g., individual and group therapy, psychiatric evaluation, etc.) are delivered according to AMA minimum timeframes, the agency can bill for the full rate (e.g., a 40-minute visit can be billed for a 45-minute session). OASAS requires that if the full 45 minutes is not provided, the agency must bill for a 30-minute visit. Mistakes can lead to disallowances during audits, so agencies are in financial peril if staff do not properly code and bill for services that may be OASAS and OMH services that may be delivered by the same clinicians.

Recommendation: If OMH and OASAS aligned their regulatory framework, community outpatient providers would experience an extraordinary reduction in administrative burden, billing challenges and staff training requirements. Clinicians at these outpatient programs would likely have more time to provide critical services to New Yorkers in need because they would have less paperwork. There would potentially be fewer billing disallowances and compliance issues, streamlining monitoring for NYS, because billing codes would be simplified and differences among the three licenses would be reduced.

The Partnership for Integrated Care looks forward to constructive conversations with the NYS regulatory agencies to simplify the regulatory and reimbursement frameworks for integrated care in 2024 and reduce the administrative burden experienced by NYS's behavioral health providers.

The Partnership for Integrated Care is a collaboration between NYS Council for Community Behavioral Healthcare and InUnity Alliance. The Partnership is dedicated to helping community-based providers further integrated care.

This paper has been funded through a grant from the New York Community Trust and prepared by Cindy Freidmutter, CLF Consulting.