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Integration of Behavioral and Physical Health Care: Licensing and Reimbursement Barriers and Opportunities in New Jersey

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Support for this Report was provided by a grant from The Nicholson Foundation.

Acronyms Frequently Used in This Report

ACF – DOH-licensed ambulatory care facility

ASO – administrative service organization

BH – behavioral health

BHH – behavioral health home

DHS – New Jersey Department of Human Services

DMHAS – DHS’s Division of Mental Health and Addiction Services

DMAHS – DHS’s Division of Medical Assistance and Health Services

DOH – New Jersey Department of Health

FQHC – Federally Qualified Health Center

HAB/HABI – health and behavior

LCSW – licensed clinical social worker

MCO – managed care organization

MHP – DHS-licensed mental health program

PCP – primary care provider

PH – physical health

PPS – Prospective Payment System

SA – DHS-licensed outpatient substance abuse treatment facility

SAMHSA – Substance Abuse and Mental Health Services Administration

SBIRT – Screening, Brief Intervention, Referral, and Treatment

SMI – severe mental illness



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Executive Summary

People with behavioral health conditions suffer from missed health care opportunities. Research has shown that people with serious mental illness suffer from increased burdens of sickness and early death as a result of poorly managed physical illness. People with less significant behavioral conditions too often remain unconnected to mental health or substance use disorder care because such services are unavailable in primary care settings. Clinicians responding to these system deficits advocate care integration through bringing primary care and behavioral health under one roof.

Innovative New Jersey clinicians have worked toward behavioral health integration. The clinical difficulties such integration entails can be daunting, but models from around the country, as well as home-grown efforts, point the way toward success. The Nicholson Foundation has funded several care integration efforts around New Jersey. Clinicians reported, however, that their efforts are impeded by legal barriers in New Jersey's licensure and reimbursement systems. The Nicholson Foundation asked Seton Hall Law School's Center for Health & Pharmaceutical Law & Policy to examine those legal barriers, and to propose solutions that would facilitate appropriate behavioral health integration.

This Report reviews the clinical behavioral health literature and describes the statutory and regulatory law on licensure and reimbursement. It reflects extensive conversations with many primary care and behavioral health providers, academics, advocates, and government representatives. The generosity of these interlocutors greatly aided in translating the general and formal to the specific and contextual, allowing us to understand the law *as applied* to behavioral health integration efforts. The openness and candor of government representatives at all levels were particularly helpful.



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Support for this Report was provided by a grant from The Nicholson Foundation.

The goals of this Report are several. **First**, the statutory and regulatory framework is complex, and the regulated community experiences confusion that impedes efforts to extend care. One goal, therefore, is to describe in clear terms both the “black letter” law and, equally as important, authoritative interpretations of that law as applied to behavioral health integration.

Second, the Report describes those instances in which current law impedes the development of integrated care. In some instances New Jersey law appears to lag the clinical developments in this area, suggesting that modifications in the law could benefit all. This Report details such areas in the licensure and reimbursement areas.

Finally, this Report offers recommendations for adjustments to the regulatory framework governing reimbursement and licensure, which recommendations are intended appropriately to balance the consumer protection missions of the Departments of Human Services and Health on the one hand with the imperative to facilitate the move to clinically integrated behavioral health and primary care services. One extremely positive development is that, during the course of the Report’s development, the New Jersey Departments of Human Services and Health announced a forward-looking policy innovation allowing the sharing of clinical space for behavioral and primary care in licensed facilities. The Departments’ movement is consistent in many regards with recommendations in this Report, and suggests continuing regulatory advances to accommodate integrated care.

The literature on clinical advances to behavioral health integration, as briefly summarized in this Report, provides both important areas of consensus and areas of continuing development.

- **The drive to integrate primary and behavioral health care responds to the evidence that people with serious behavioral health conditions suffer for lack of access to primary care, while people with mild to moderate behavioral health conditions, too often unconnected to behavioral health care, could benefit from access to care in primary care settings.**
- **The drive to integrate care goes beyond merely increasing access; rather, studies demonstrate that behavioral health integration can improve patient outcomes.**
- **There is a growing body of literature indicating that integrating care is cost-neutral or cost-saving. Many high-utilizers of hospital emergency department services have behavioral health conditions, and appropriate community care of both their behavioral health and physical health needs could reduce the need for expensive hospital-based care.**
- **Best practices for behavioral health integration are still emerging, and various models, tailored to particular populations and settings, continue to develop.**
- **Development of behavioral integration faces several environmental barriers, including gaps in reimbursement, low Medicaid reimbursement rates, and onerous licensure standards.**

Many New Jersey behavioral health and primary care providers regard licensure rules to be a principal barrier to integrated care. Discussions with these providers revealed that there is a great deal of confusion among the regulated community as to New Jersey's licensure rules.

- **Federally Qualified Health Centers (FQHCs) and other outpatient clinics are an important source of primary care for New Jerseyans with low or moderate incomes. FQHCs are licensed by the Department of Health (DOH) as Ambulatory Care Facilities (ACFs).**
- **The ACF regulations list permissible services, which include some limited outpatient substance use disorder treatment but not mental health services. Mental health programs (MHPs) and outpatient substance abuse treatment facilities (SAs) are licensed by the Department of Human Services (DHS). This structure suggests that a facility attempting to provide integrated behavioral health and primary care services could be required to obtain two or three separate licenses, an onerous and time-consuming task.**
- **In practice, however, both DOH and DHS permit DOH-licensed FQHCs to provide limited mental health services, such as screening, brief intervention, and limited counseling and medication management, without being licensed by DHS.**
- **The extent to which DOH and DHS permit ACFs to provide behavioral care is quite ambiguous in New Jersey's laws and regulations.**
- **Mental health programs and outpatient substance use disorder treatment programs licensed by DHS are not permitted to provide most primary care services without obtaining a separate ACF license from DOH; however, DHS-licensed mental health programs are often permitted, by informal arrangement, to provide up to eight hours of primary care per week without a DOH license.**
- **Hospital-based outpatient facilities located away from the hospital campus must be separately licensed as ACFs by DOH. In addition, if a hospital licensed for mental health care does not offer outpatient behavioral health services on its hospital campus and operates more than one off-campus outpatient behavioral health facility, DOH will only consider one of these programs as being under the hospital's license; additional such facilities must be licensed by DHS as a MHP.**
- **It is unclear whether hospital-based outpatient clinics are permitted to provide integrated behavioral health and primary care services without obtaining a license from DHS, although DOH acknowledged that integration may be appropriate in certain circumstances.**

A major sticking point with many facilities striving to provide integrated care has been the State's position that licensure provisions prohibited providing behavioral and primary care in the same clinical space. A memorandum released as this Report was going to press, referred to here as the Shared Space Waiver, and described in detail in Part III(B)(9)a) below, substantially relaxed that requirement for ACFs.

- Prior to the publication of the Shared Space Waiver, providers reported being told that they must maintain separate entrances, stairways, restrooms, waiting rooms, examination rooms, staff break rooms, and other duplicative facilities. Some, but not all, of those separation requirements were acknowledged by DOH as requirements, although it was reported that waivers were available for some of the separate facilities requirements.
- Many of these “keep separate” requirements appear to run contrary to nondiscrimination requirements, including those of the Americans with Disabilities Act.
- The Shared Space Waiver, issued by DOH pursuant to the Commissioner’s waiver authority, relieves many facilities of most of those “keep separate” requirements for facilities seeking licensure from both DOH and DHS. This Shared Space Waiver is described in detail in Part III(B)(9)a) below.

In addition to licensure barriers, payment issues inhibit behavioral health integration in many circumstances.

- The system by which FQHCs and other ACFs may be paid by Medicaid for behavioral health services is complex and poorly understood by providers. The instructions for and implementation of Medicaid billing is located in several uncodified locations, subject to interpretation by several sources, and has been reported to be inconsistently administered.
- Although DHS has taken the position that DOH-licensed ACFs must also be licensed as mental health programs by DHS in order to bill Medicaid for mental health services, DHS has approved, through the distribution of informal guidance, certain limited reimbursement codes to be activated for FQHCs to provide some limited behavioral health services.
- Almost all Medicaid recipients in New Jersey are now covered by Medicaid Managed Care Organizations (MCOs). Because New Jersey Medicaid operates with a behavioral health carve-out, however, some but not all behavioral health services are not reimbursed by MCOs, but by an independent contractor on a fee-for-service basis. This system has created some confusion, and DHS has shifted management of Medicaid payment for substance use disorder treatment to Rutgers University Behavioral Health Care, and is in the process of reexamining the system by which mental health care is reimbursed.
- FQHCs receive Medicaid payment through a unique prospective payment system, intended to compensate them for providing a broad range of comprehensive clinical and other health-related services.
- The FQHCs’ prospective payment rate is adjusted to account for medical inflation. In addition, the amount of payment is required to be adjusted when an FQHC experiences a “change in scope of services.”

- **The precise definition of what constitutes a change in scope, triggering an adjustment to the FQHCs' payment rate, is not defined in federal or state statute, and the law accords some discretion in such matters to the states.**
- **A long-standing dispute between many FQHCs and the DHS has centered on precisely when a modification of services is such that an application for a change in scope application must be filed. This dispute appears to be a factor in some FQHCs' decision to add behavioral health services sufficient to permit the integration of primary and behavioral care.**

Part V of this Report includes a series of recommendations for adjustments to the licensure and reimbursement rules in New Jersey in order to facilitate the adoption of behavioral health integration. Those recommendations are summarized below.

- **DHS and DOH should collaborate to simplify the regulatory requirements for integrated care, as the agencies did in publishing a Waiver to Permit the Sharing of Clinical Space on October 19, 2015 (the Shared Space Waiver).**
- **The Departments should collaborate to facilitate the dual licensure of providers to operate integrated care facilities, and over time should move to a single license for the operation of an integrated facility, with collaborative sharing of expertise between the agencies.**
- **Regulatory requirements for separation of behavioral and primary care services should be eliminated, a goal significantly advanced by the Shared Space Waiver; building on that step, the agencies should eliminate all requirements for separation except for those, such as records maintenance, required by law. Facilities regulations should be functional, encouraging shared space and services where not inconsistent with patient needs.**
- **Medicaid payment rates for primary care and behavioral health services, including those paid through Medicaid managed care organizations, should be reviewed in order to assure sufficient financing to sustain integrated care.**
- **DHS should continue to pursue initiatives such as Behavioral Health Homes and the Certified Community Behavioral Health Clinics project to ensure that people with serious and persistent behavioral health needs have access to necessary physical health services in an integrated setting.**
- **The Change of Scope process for FQHC reimbursement should not be allowed to serve as a barrier to FQHCs' ability to maintain or add behavioral health services for mild to moderate behavioral health conditions.**
 - **DHS should clarify the extent to which FQHCs can provide care for mild or moderate conditions without requiring a change of scope filing; and**

- **If such a filing is required, DHS and regulated entities should engage in a collaborative process to ensure that regulatory requirements do not impede efforts to serve the needs of patients.**
- **Health care providers in New Jersey attempting to provide integrated physical and behavioral health services are confused, and appear to receive inconsistent guidance on licensure and reimbursement. DHS and DOH should provide more user-friendly tools to combat confusion in the regulated community. Such steps might include:**
 - **FAQs and more complete descriptions of regulatory policy on integration on agency web sites.**
 - **Public outreach to mental health programs, FQHCs and other primary care providers, hospitals, and their trade organizations with full descriptions of agency policy.**

RECOMMENDATIONS

INTEGRATION OF BEHAVIORAL AND PHYSICAL HEALTH CARE: LICENSING AND REIMBURSEMENT BARRIERS AND OPPORTUNITIES IN NEW JERSEY SETON HALL LAW – MARCH 31, 2016

Recommendation #1

New Jersey should move toward a system requiring only a single license for the operation of an integrated facility. Interim steps advancing DOH and DHS toward a single licensure system, such as the collaboration leading to the Shared Space Waiver, should be undertaken to minimize the impediments to implementing clinically appropriate integrated facilities.

Recommendation #2

Regulatory requirements for separation of behavioral and primary care services should be eliminated, as DOH accomplished with the Shared Services Waiver, except for those, such as records maintenance, required by law. Facilities regulations should be functional, encouraging shared space and services where not inconsistent with patient needs.

Recommendation #3

Medicaid payment rates for primary care and behavioral health services through fee-for-service and Medicaid managed care organizations should be reviewed in order to assure sufficient levels to permit sustainable integrated care.

Recommendation #4

DHS, in determining the shape of its fiscal agency model under the Comprehensive Waiver, should consider contracting with a single agent for both physical and behavioral health care claims.

Recommendation #5

DHS should continue to pursue initiatives such as Behavioral Health Homes and the NJ CCBHC project to ensure that people with serious and persistent behavioral health needs have access to necessary physical health services in an integrated setting.

Recommendation #6

DHS should use the period of transition to new agents and intermediaries to adjust the terms and conditions of Medicaid participation and payment to facilitate behavioral health integration.

Recommendation #7

FQHCs should be permitted to maintain or add behavioral health services to screen and provide services for mild to moderate behavioral health conditions without filing a Change of Scope application; the addition of services for severe and persistent behavioral health conditions should, however, trigger such a requirement.

Recommendation #8

The Departments of Human Services and Health should identify staff with responsibility for integration efforts and provide full and public disclosure of their regulatory policies for the benefit of providers and regulatory personnel in the form of (1) FAQs and more complete descriptions of regulatory policy on integration on agency web sites; and (2) Public outreach to mental health programs, substance use disorder programs, FQHCs and other primary care providers, hospitals, and their trade organizations with full descriptions of agency policy.

I. Introduction

A solid clinical consensus has existed for decades that behavioral and physical health care should not be separated.¹ The health regulatory and finance system nationally, however, has lagged behind this clinical judgment. As a result, people with behavioral health needs (that is, for mental health and/or substance use disorder care) experience fragmented care. The lapses in the care delivery system manifest in many ways, but two clusters of concern stand out. People with serious mental illness tend to obtain much of their care in specialty mental health clinics and facilities, where they are unlikely to receive primary physical health care; people with less serious behavioral health needs tend to access care with primary physical health providers, where they are unlikely to be screened or receive treatment for mental health or substance abuse conditions.

The experience of harm from the fragmentation of health care is not peculiar to those with behavioral health needs. Rather, the problem is widespread throughout the health care delivery system, creating care gaps for patients and inefficiencies in health care finance.² But for those with behavioral health needs, the concerns are particularly acute. People with severe mental illness experience disproportionately high mortality and morbidity rates, and have been found to die, on average, 25 years earlier than the general population. Very few of the early deaths are attributable to suicide or accidents directly attributable to mental illness. Instead, they are due to general medical causes including treatable chronic conditions, such as vascular, respiratory, and cardiac disease, for which they too often receive little or no treatment.³

People with less severe behavioral health concerns face a different effect from the system's fragmentation. People with less severe behavioral health concerns are often treated primarily or exclusively in primary or specialty physical care settings, and receive little or no diagnosis or treatment for their behavioral health conditions. The treatment of these patients' behavioral health conditions is hampered by several factors, including the absence of mental health and substance use disorder professionals in many primary care settings, and the lack of support and training many primary care physicians receive for behavioral health care.⁴ In addition, the lack of appropriate behavioral health care in primary care settings can impair patients' physical health treatment.⁵

¹ See Larry A. Green & Maribel Cifuentes, Editorial: *Advancing Care Together by Integrating Primary Care and Behavioral Health*, 28 J. AM. BOARD FAM. MED. S1 (2015) ("Separating the care of people with emotional and behavioral problems into physical and mental compartments and organizing 2 systems of care to meet their needs has been known to be a mistake for decades.").

² See generally THE FRAGMENTATION OF U.S. HEALTH CARE: CAUSES AND SOLUTIONS (Einer Elhauge, Ed. 2010).

³ Joseph P. McEvoy *et al.*, *Prevalence of the Metabolic Syndrome of Patients with Schizophrenia*, SCHIZOPHRENIA RESEARCH at 19-32 (Dec. 2005).

⁴ See Ron Manderscheid & Roger Kathol, *Fostering Sustainable, Integrated Medical and Behavioral Health Services in Medical Settings*, 160 ANNALS OF INTERNAL MED. 61, 61 (2014). See generally Parts II(A) and (B) *infra*.

⁵ See Manderscheid & Kathol, *supra* note 4, at 61.

When we refer to physical health in this Report, we mostly are concerned with the delivery of primary health care. The Johns Hopkins Primary Care Policy Center defines primary care as “the level of a health services system that provides entry into the system for all new needs and problems, provides person-focused (not disease-oriented) care over time, provides care for all but very uncommon or unusual conditions, and coordinates or integrates care, regardless of where the care is delivered and who provides it. It is the means by which the two main goals of a health services system, optimization and equity of health status, are approached.”⁶ With respect to behavioral health care, we envision a “continuum of services for individuals at risk of, or suffering from, mental, addictive, or other behavioral health disorders.”⁷ This broad conception of behavioral health includes, for example, behavioral health screening and assessment in addition to treatment.

This Report will examine particular aspects of the disjunction between physical and behavioral health care in New Jersey. Health care providers interested in integrating behavioral health and primary care reported experiencing legal and regulatory difficulties in those efforts. It was reported by providers associated with hospitals, federally qualified health centers (FQHCs), mental health programs (MHPs), and others that the adoption of integrative methods of care for people with behavioral health concerns was impeded by Medicaid payment issues, and requirements of the licensing system of the New Jersey Department of Health (DOH), Department of Human Services (DHS), or both. The authors of this Report examined New Jersey’s laws, regulations, and practices in the relevant licensure and payment systems. We met with health care providers pursuing integration, to understand their relevant regulatory concerns. And we met with government officials to clarify the State’s practices in these regulatory areas, and to understand the regulators’ perspectives on those measures seen by the regulated industry as barriers to clinical integration.

We heard from providers that they have difficulty understanding how regulators interpret and apply their licensure regulations when a primary care provider such as an FQHC wishes to add some measure of behavioral health services, or when a MHP seeks to add some primary physical health services. For example, federal law permits FQHCs to provide behavioral health services, and in some situations requires Medicaid reimbursement for those services,⁸ and many

⁶ JOHN HOPKINS BLOOMBERG SCHOOL OF PUBLIC HEALTH, THE JOHN HOPKINS PRIMARY CARE POLICY CENTER, Definitions, <http://www.jhsph.edu/research/centers-and-institutes/johns-hopkins-primary-care-policy-center/definitions.html> (last visited Dec. 8, 2015).

⁷ MARY TAKACH, KITTY PURRINGTON & ELIZABETH OSIUS, A TALE OF TWO SYSTEMS: A LOOK AT STATE EFFORTS TO INTEGRATE PRIMARY CARE AND BEHAVIORAL HEALTH IN SAFETY NET SETTINGS, NATIONAL ACADEMY FOR STATE HEALTH POLICY 5 (2010), available at http://www.nashp.org/sites/default/files/TwoSystems_0.pdf (quoting U.S. Dep’t of Health & Human Servs., Substance Abuse & Mental Health Servs. Admin., Nat’l Mental Health Info. Ctr., <http://mentalhealth.samhsa.gov/resources/dictionary.aspx>).

⁸ See U.S. DEP’T OF HEALTH & HUMAN SERVS., HEALTH RESOURCES & SERVS. ADMIN., BUREAU OF PRIMARY HEALTH CARE, “Medicaid Reimbursement for Behavioral Health Services,” BPHC Program Information Notice 2004-05 (Oct. 31, 2003), available at <http://bphc.hrsa.gov/policiesregulations/policies/pdfs/pin200405.pdf>.

FQHCs have expressed interest in offering integrated primary behavioral health services. State regulation presents impediments to those goals. Several FQHCs, licensed in New Jersey as ambulatory care facilities (ACFs) by the Department of Health, reported that they have been told by the State that they may not offer behavioral health services without also obtaining a license as a MHP by the Department of Human Services. Yet, as discussed in more detail in Part IV below, for many years FQHCs have been providing some behavioral health services without a MHP license, using a set of codes provided by Medicaid. Some FQHCs, however, reported occasional and difficult-to-understand denials of payment for some of their behavioral health claims without clear explanation, while Medicaid reported that its practice is to provide a reason for each denial.

One puzzle for FQHCs is interpreting the interplay between the extent of behavioral services they aspire to provide and the level of licensure required. Some FQHCs have long provided “primary” behavioral health services – that is, routine outpatient services for people without serious mental illness. Communications with regulators have led these FQHC providers to believe that they will need to be licensed as MHPs by the Department of Human Services if they continue to provide these behavioral health services. These FQHCs report that they regard this additional licensure requirement as costly and burdensome. In addition, they argue that these services are squarely within their mission, as their primary care patients are underserved in primary behavioral health services.

Other FQHCs reported that they aspire to be licensed as MHPs in order to provide more intense services for people with severe mental illness. These FQHCs described what they perceive as barriers to achieving dual licensure. They report being advised by regulators of substantial facilities requirements, such as providing separate entrances, waiting rooms, and lunch rooms. Even facilities with the ability to design facilities to meet different licensing standards faced frustration and delays because they had difficulty obtaining definitive guidance from the State regarding the nature of the requirements for dual licensure. Others report being told that, as FQHCs, they categorically are not eligible to be licensed as mental health providers.

We also heard from MHPs that faced obstacles when they tried to add physical health services. They were advised that they would need to be licensed as ambulatory care facilities if they added any substantial primary care services. We heard estimates of \$125,000 to \$250,000 to retrofit existing facilities or build out raw space. These providers also were informed of requirements for separation of behavioral and physical health space, although some waivers were granted. But there were some requirements that the State reportedly would not waive, including having separate examination rooms, separate bathrooms and hallways in clinical treatment areas, and separate human resources and training systems. MHPs objected to many of these requirements, arguing that they tend to perpetuate separate, isolating facilities and frustrate attempts to encourage or facilitate integration. A common theme was the opacity of the process, and many called for greater clarity and transparency in order to allow them to move forward.

Some hospital-based outpatient programs similarly have expressed confusion about how or whether they may integrate primary physical and behavioral health services. We have been told, for example, that a hospital would not be permitted to offer outpatient behavioral health services in its outpatient physical health clinic even though it already provides the same services in its outpatient behavioral health clinic.

Our discussions with providers highlighted many barriers to integration, but also – and perhaps as significantly – that the process of moving to behavioral health integration is affected by regulatory opacity and confusion. We had the opportunity to meet on several occasions with representatives of the two principal Departments – the Department of Health and the Department of Human Services – including the Commissioners and their senior staff members. They were, without exception, open and generous with their time, answering our questions frankly, and suffering several follow-up sessions. It is clear that the Departments are fully aware of the need to address regulatory barriers to integration. Senior staff from the two Departments have discussed over a long period of time means to achieve appropriate rules for integration within the obligations of the Departments to protect those within their regulatory mandates.

This Report is fundamentally forward-looking. It is the authors' goal to advance the chances for appropriate integration of behavioral health and primary care. In furtherance of that goal, we will provide our analysis of the current state of regulatory affairs. We will note where we believe that regulated entities are poorly served by opacity and ambiguity in the regulatory process. We will note where we have concerns that some current practices appear contrary to clinical trends toward integrated settings and services, and where some regulatory practices seem contrary to the spirit of mandates to advance nondiscrimination and to maximize social integration. We will set out recommendations for regulatory modifications to address those concerns. We must clearly state: we fully understand that the Departments of Human Services and Health fully embrace these goals. This Report should not be taken as criticism of unwilling government regulators. Instead, we hope that it will be of assistance to skilled and committed professionals in both agencies who have a depth of understanding and experience on these issues that will serve the State well as these issues move forward.

We provide a caution to readers: we have examined these important issues with seriousness and purpose. But we acknowledge from the outset that there are complexities and nuances that will require collaboration and effort from all concerned if New Jersey is to advance its interest in behavioral health integration. We hope this Report is helpful, but we recognize that there is much more to the issues than is described here. In particular, reimbursement issues – how society funds essential care for people with mental health and substance use disorders – will require sustained collaborative work.

Part II of this Report provides an overview of the wide body of literature regarding integrating primary physical and behavioral healthcare delivery through a number of lenses, including patient outcomes, cost-effectiveness, barriers to integration, and models of integrated

care. Part III addresses licensure issues. It describes the shared responsibility of the Departments of Human Services and Health, the harmonies and discords that result from that shared responsibility, and the confusion and ambiguity that sometimes infect the accomplishment of the Departments' regulatory mandates. Part IV addresses payment issues. It acknowledges the broad belief among providers and commentators that funding for behavioral health services lags the needs of the affected community. It also addresses the complex issues of payment to FQHCs, and the effects the addition of behavioral health services may have on their financial status. Part V provides our recommendations for steps to clarify and adjust New Jersey's licensure and payment regulatory structure to advance broadly-embraced goals of behavioral health integration. We hope and believe, on the basis of our discussions with regulators, that these recommendations will be received by the Departments as helpful.

As this Report was going to press, the Department of Health released a memorandum regarding "Waiver to Permit Sharing of Clinical Space."⁹ It describes the Department's creation of a "global waiver to permit the sharing of clinical space" to facilitate the integration of behavioral and primary care in some settings. The memorandum, referred to in this Report as the "Shared Space Waiver," simplifies the Department of Health's licensure requirements for integrated care in licensed primary care settings, and will be discussed in detail in Part III(B) below. The Shared Space Waiver does not directly affect the ability of licensed MHPs or outpatient substance use disorder treatment programs to add primary care services (discussed in Part II(B)(3) and (5) below), nor does it address the financing issues of concern to those seeking to add behavioral health in primary care facilities licensed by the Department of Health (discussed in Part IV(B)(2) below).

⁹ See October 19, 2015 Memorandum to FQHCs and Other Department of Health Licensed Primary Care Facilities, Primary Care Association from John A. Calabria, Director of the New Jersey Department of Health, Division of Certificate of Need and Licensing, Re: Waiver to Permit Sharing of Clinical Space [hereinafter Shared Space Waiver], available *at* http://www.nj.gov/health/healthfacilities/documents/ac/primary_care_facilities_permitting_sharing_of_clinical_space.pdf (attached to this Report as Appendix B).

II. Literature Review

A. Background

Across the country, efforts are being made to treat people's behavioral and physical health care needs in a more coordinated, collaborative, or integrated way.¹⁰ Some of these efforts focus on providing physical health care services in behavioral health care settings, while others focus on bringing behavioral health care services into physical health care settings.¹¹ The former is important because the physical health care needs of individuals with serious and persistent mental illness often go unmet. The latter is important too, because, as Ron Manderscheid and Roger Kathol explain, "most patients with [behavioral health (BH)] conditions are seen exclusively in either primary or specialty medical care settings, but most do not receive BH assessments and treatment."¹² Manderscheid and Kathol go on to report that "although nearly 50% of patients with chronic medical diseases have comorbid BH conditions, more than 80% of the BH conditions remain untreated or ineffectively treated in primary and medical specialty settings."¹³ This is concerning for many reasons, including that "[u]ntreated BH conditions in the primary care setting are associated with treatment nonresponse, illness persistence, higher medical illness complication rates, disability, increased health care service use, higher health care costs, and premature death."¹⁴

The term "integration" is defined in a number of different ways and used to denote a wide variety of approaches to care provision.¹⁵ The federal Center for Integrated Health Solutions¹⁶ has developed a six-level rubric, which arrays approaches to service provision on a continuum from Level 1, which is characterized by minimal collaboration between behavioral and physical health care providers, to Level 6, which is characterized by full collaboration in an integrated

¹⁰ CHRIS COLLINS, DENISE LEVIS HEWSON, RICHARD MUNGER & TORLEN WADE, *EVOLVING MODELS OF BEHAVIORAL HEALTH INTEGRATION IN PRIMARY CARE*, MILBANK MEMORIAL FUND 1 (2010) (hereinafter "EVOLVING CARE"), *available at* <http://www.milbank.org/uploads/documents/10430EvolvingCare/EvolvingCare.pdf>.

¹¹ *Id.*

¹² Manderscheid & Kathol, *supra* note 4, at 61 (internal citations omitted).

¹³ *Id.* (internal citations omitted).

¹⁴ *Id.* (internal citations omitted).

¹⁵ Shandra M. Brown Levey, Benjamin F. Miller & Frank Verloin deGruy, *Behavioral Health Integration: An Essential Element of Population-Based Healthcare Redesign*, 2 TBM 364, 365 (2012) ("Integration must involve linking primary care providers with mental health providers, but interpretations, strategies, and definitions of integration are highly variable. . . . [I]t is imperative that practices and systems of care carefully define their terms and models of care."); *EVOLVING CARE*, *supra* note 10, at 6 (noting that one proposal would define collaborative care as "behavioral health working with primary care" and integrated care as "behavioral health working within and as a part of primary care").

¹⁶ About Us, SAMHSA-HRSA Center for Integrated Health Solutions, <http://www.integration.samhsa.gov/about-us> (last visited July 22, 2015) ("The SAMHSA-HRSA Center for Integrated Health Solutions (CIHS) promotes the development of integrated primary and behavioral health services to better address the needs of individuals with mental health and substance use conditions, whether seen in specialty behavioral health or primary care provider settings. CIHS is funded jointly by the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Health Resources and Services Administration (HRSA), and run by the National Council for Behavioral Health.").

practice.¹⁷ At Levels 1 and 2, care is provided at separate locations, while at Levels 3 and 4, care is co-located, meaning that behavioral and physical health care are provided in one location.¹⁸ At Level 5, behavioral and physical health care providers “begin to function as a true team,” while at Level 6,

[f]uller collaboration between providers has allowed antecedent system cultures (whether from two separate systems or from one evolving system) to blur into a single transformed or merged practice. Providers and patients view the operation as a single health system treating the whole person. The principle of treating the whole person is applied to all patients, not just targeted groups.¹⁹

A frequently cited example of a fully integrated model is Cherokee Health Systems (CHS) in Tennessee.²⁰ CHS originally was a community mental health center, but it expanded to become a federally qualified health center (FQHC).²¹ As a result, it receives a capitated rate for providing integrated primary care and behavioral health services at 22 sites.²² CHS embeds a behavioral health team in its primary care practice, which “provides consultation, assessment, and intervention to address a number of issues ranging from traditional mental health (e.g., depression, anxiety, and diagnostic clarification) to health psychology issues (e.g., self-management of diabetes, asthma, healthy diet, smoking cessation programs for teenagers, etc.).”²³ The model also includes a specialty mental health clinic that “provides psychiatric

¹⁷ BERN HEATH, PAM WISE ROMERO & KATHY REYNOLDS, A STANDARD FRAMEWORK FOR LEVELS OF INTEGRATED HEALTHCARE, SAMHSA-HRSA CENTER FOR INTEGRATED HEALTH SOLUTIONS 4 (2013), available at http://www.integration.samhsa.gov/integrated-care-models/A_Standard_Framework_for_Levels_of_Integrated_Healthcare.pdf.

¹⁸ *Id.*

¹⁹ *Id.* at 6.

²⁰ See, e.g., DEBORAH J. COHEN, ET AL., AGENCY FOR HEALTHCARE RESEARCH AND QUALITY, A GUIDEBOOK OF PROFESSIONAL PRACTICES FOR BEHAVIORAL HEALTH AND PRIMARY CARE INTEGRATION: OBSERVATIONS FROM EXEMPLARY SITES MARCH 2015., available at http://integrationacademy.ahrq.gov/sites/default/files/AHRQ_AcademyGuidebook.pdf (identifying CHS as one of eight high-performing primary care organizations with integrated behavioral health and primary care); EVOLVING CARE, *supra* note 10, at 36 (highlighting CHS as an example of a unified primary and behavioral health program); NAT’L ASSOC’N OF COMMUNITY HEALTH CTRS., EDUCATIONAL HEALTH CENTERS: TEACHING AND LEARNING IN THE COMMUNITY, at 1, 8 (Nov. 2015) (identifying CHS as a “Best Practice” Educational Health Center Site: “CHS is known across the country as being one of the nation’s leading “best-practice” programs in the integration of behavioral health and primary care, and they have also become known for their ability to train health professionals in this 21st-century, integrated, collaborative-care model”), available at <http://www.nachc.com/client/Educational%20Health%20Centers%20Teaching%20and%20Learning%20in%20the%20Community%20Case%20Studies%20Final%20Report%20November%202015.pdf>.

²¹ See EVOLVING CARE, *supra* note 10, at 36.

²² See *id.*

²³ U.S. DEP’T OF HEALTH & HUMAN SERVS., AGENCY FOR RESEARCH & HEALTHCARE QUALITY, Integration at Cherokee Health Systems, <http://integrationacademy.ahrq.gov/content/Integration%20at%20Cherokee%20Health%20Systems> (last visited Dec. 11, 2015).

consults, case management, therapy, and followups as needed using face-to-face as well as telemedicine.”²⁴ CHS reportedly has seen reduced use of emergency medical services by its patients since focusing on integrated care.²⁵

B. Integrated Care and Patient Outcomes

A growing body of empirical evidence supports the proposition that integrating behavioral and physical health care can lead to improved patient outcomes. Many patients who would benefit from behavioral health treatment turn to physical health providers for help with physical health concerns that do not have an organic cause. These patients might not be aware that they would benefit from behavioral health services, or they might hesitate to seek them out due to stigma or other reasons. It is estimated that around “75% of patients with depression present physical complaints as the reason they seek health care.”²⁶

The authors of a recent Cochrane Review analyzed seventy-nine randomized controlled trials comparing collaborative care with usual care or with alternative treatments for anxiety and depression.²⁷ The authors considered care to be “collaborative” if: (1) it was delivered by a primary care provider and at least one other health professional; (2) it was guided by a structured plan for evidence-based management of each patient’s condition; (3) it incorporated scheduled follow up with each patient; and (4) mechanisms were put in place to facilitate communication between all the members of the care team.²⁸ Among other things, the authors found that there is “clear and robust evidence of effectiveness for collaborative care in improving depression outcomes in the short- and medium-term.”²⁹ The studies that examined the effect of collaborative care on anxiety, while much smaller in number than those examining depression, similarly provide evidence of the effectiveness of collaborative care.³⁰

²⁴ *Id.*; see also Eboni Winford, Behavioral Health Consultant, Cherokee Health Systems, *The Integration of Behavioral Health and Primary Care: A Leadership Perspective* (Oct. 10, 2014), available at http://c.ymcdn.com/sites/www.tnpca.org/resource/resmgr/Leadership_Conference_2014/IntegrationofBehavioralHealth.pdf (providing overview of CHS model).

²⁵ See DARCY GRUTTADARO & DANA MARKEY, NAT’L ALLIANCE ON MENTAL ILLNESS, *A FAMILY GUIDE: INTEGRATING MENTAL HEALTH AND PEDIATRIC PRIMARY CARE*, at 32 (Nov. 2011), available at http://www.integration.samhsa.gov/integrated-care-models/FG-Integrating_12.22.pdf.

²⁶ Jürgen Unützer, Michael Schoenbaum, Benjamin G. Druss & Wayne J. Katon, *Transforming Mental Healthcare at the Interface with General Medicine: Report of the President’s New Freedom Commission on Mental Health*, 57 *PSYCHIATRIC SERVICES* 37, 39 (2006) [hereinafter Unützer *et al.*, *Transforming Mental Healthcare*].

²⁷ JANINE ARCHER, PETER BOWER, SIMON GILBODY, ET AL., *COLLABORATIVE CARE FOR DEPRESSION AND ANXIETY PROBLEMS*, COCHRANE DATABASE OF SYSTEMATIC REVIEWS (2012).

²⁸ *Id.* at 4.

²⁹ *Id.* at 26. The authors do offer a number of caveats, including that the magnitude of the benefits of collaborative care relative to usual care will likely be the subject of ongoing debate. *Id.* The authors also suggest that “some benefits (such as those on physical health quality of life) are statistically significant but potentially of limited clinical significance”.

³⁰ *Id.* at 18.

Collaborative care has also proved effective for bipolar disorder, although the evidence of effectiveness is not as definitive as it is for depression and anxiety. The authors of a recent meta-analysis found that the results of 5 of 12 trials enrolling individuals with bipolar disorder favored the “collaborative chronic care model.”³¹ The authors suggest that the results could be mixed because bipolar disorder is “chronic and typically accompanied by multiple comorbidities.”³² In addition, “mental health treatment settings may represent more complex organizational challenges than primary care for implementation of care management models.”³³ A recent Cochrane Review evaluated a study of veterans with bipolar disorder and concluded that collaborative care significantly reduced the chance of inpatient psychiatric treatment over the course of the following year.³⁴ Concomitantly, there is empirical evidence that integrating primary physical health care into specialty mental health settings can result in improved physical health outcomes.³⁵

C. Integrated Care and Cost

In addition to being effective, there is also evidence that integrated care is cost effective, and that it can be cost neutral or even save money under certain circumstances. Addressing patients’ behavioral health needs in addition to their physical health needs can lead to a “medical cost offset,” which occurs when mental health treatment is “used programmatically to reduce medical costs in a way that would more than pay for the cost of the mental health treatment.”³⁶ A meta-analysis by Jeremy Chiles and his colleagues of 91 studies evaluating the effect of a variety of psychological interventions on medical utilization found that mental health treatment was associated with a 15.7% reduction in utilization, as compared to an average increase in utilization for patients in the untreated control groups of 12.27%.³⁷

The potential for medical cost offset is particularly high when mental health treatment reduces a patient’s need for hospitalization.³⁸ According to a recent study by the Rutgers Center for State Health Policy (CSHP), Medicaid beneficiaries in New Jersey frequently hospitalized for physical health conditions are significantly more likely than other Medicaid beneficiaries to have

³¹ Emily Woltmann, Andrew Grogan-Kaylor, Brian Perron, *et al.*, *Comparative Effectiveness of Collaborative Chronic Care Models for Mental Health Conditions Across Primary, Specialty, and Behavioral Health Care Settings: Systematic Review and Meta-Analysis*, *AMERICAN JOURNAL OF PSYCHIATRY* 790, 795 (2012) (finding that the results of 5 of 12 trials enrolling individuals with bipolar disorder favored the “collaborative chronic care model”).

³² *Id.* at 797.

³³ *Id.* at 797-98.

³⁴ Siobhan Reilly, Claire Planner, Linda Gask, *et al.*, *Collaborative Care Approaches for People with Severe Mental Illness*, *COCHRANE DATABASE OF SYSTEMATIC REVIEWS* (2012).

³⁵ MARY BUTLER, ROBERT L. KANE, DONNA MCALPINE ET AL., *INTEGRATION OF MENTAL HEALTH/SUBSTANCE ABUSE AND PRIMARY CARE*, *AGENCY FOR HEALTHCARE RESEARCH AND QUALITY* 41 (2008).

³⁶ Alexander Blount, Michael Schoenbaum, Roger Kathol, *et al.*, *The Economics of Behavioral Health Services in Medical Settings: A Summary of the Evidence*, 38 *PROF. PSYCH.: RES. AND PRACTICE* 290, 291 (2007).

³⁷ Jeremy A. Chiles, Michael J. Lambert & Arlin L. Hatch, *The Impact of Psychological Interventions on Medical Cost Offset: A Meta-analytic Review*, 6 *CLINICAL PSYCHOLOGY: SCIENCE AND PRACTICE* 204, 209 (1999).

³⁸ *EVOLVING CARE*, *supra* note 10, at 27.

behavioral health conditions.³⁹ CSHP's research revealed that for Medicaid beneficiaries, 47.9% of avoidable or preventable hospitalizations were associated with behavioral health problems, as compared with 34.2% of unavoidable hospitalizations.⁴⁰ CSHP concluded that, for complex patients, improved integration of behavioral and physical health services could "lead to lower avoidable hospital utilization and cost savings."⁴¹ Data from the New Jersey Hospital Association show that the number of patients with a behavioral health diagnosis who came to the emergency room for treatment grew from 289,800 in 2007 to 521,000 in 2012, which suggests that the potential for savings could be significant.⁴²

In a 1997 article in *PSYCHOSOMATIC MEDICINE*, Michael Von Korff and colleagues reported on perhaps the first experimental evaluation of the cost-effectiveness of collaborative care specifically.⁴³ They studied two models, one in which primary care physicians and psychiatrists co-managed depressed patients by starting therapy with antidepressant medication, and one in which primary care physicians cared for such patients along with psychologists, who provided a brief cognitive-behavioral therapy program.⁴⁴ For patients with major depression, the experimental approaches were more cost-effective than usual care, because the patients' specialty mental health care utilization dropped.⁴⁵

In a 2008 article in the *AMERICAN JOURNAL OF MANAGED CARE*, Jürgen Unützer and his colleagues reported on a very large study that "enrolled 1801 depressed older primary care patients from 8 healthcare systems in a randomized controlled trial of [the IMPACT] collaborative care management program for depression compared with care as usual."⁴⁶ Under the IMPACT program, care is provided by a team including a primary physical health care provider, a staff member responsible for case management, such as a clinical social worker, nurse, or psychologist, and a consulting psychiatrist.⁴⁷ The team closely tracks each patient's progress

³⁹ SUJOY CHAKRAVARTY, JOEL C. CANTOR, JAMES T. WALKUP & JIAN TONG, *ROLE OF BEHAVIORAL HEALTH CONDITIONS IN AVOIDABLE HOSPITAL USE AND COST*, RUTGERS CENTER FOR STATE HEALTH POLICY ii-iii (2014).

⁴⁰ *Id.* at iii.

⁴¹ *Id.* at 6.

⁴² Beth Fitzgerald, *Behavioral Health is Major Issue in N.J.'s Low-Income Communities*, Study Finds, *NJBIZ.COM* (Nov. 19, 2014).

⁴³ Michael Von Korff, Wayne J. Katon, Terry Bush, *et al.*, *Treatment Costs, Cost Offset, and Cost-Effectiveness of Collaborative Management of Depression*, 60 *PSYCHOSOMATIC MED.* 143, 143 (1998).

⁴⁴ *Id.*

⁴⁵ *Id.* at 147. For patients with minor depression, however, the cost per case successfully treated was lower for usual care than for collaborative care. *Id.*

⁴⁶ Jürgen Unützer, Wayne J. Katon, Ming-Yu Fan, *et al.*, *Long-Term Cost Effects of Collaborative Care for Late-Life Depression*, 14 *AM. J. OF MANAGED CARE* 95, 95 (2008).

⁴⁷ JÜRGEN UNÜTZER, HENRY HARBIN, MICHAEL SCHOENBAUM, & BENJAMIN G. DRUSS, *THE COLLABORATIVE CARE MODEL: AN APPROACH FOR INTEGRATING PHYSICAL AND MENTAL HEALTH CARE IN MEDICAID HEALTH HOMES*, CENTER FOR HEALTH CARE STRATEGIES AND MATHEMATICA POLICY RESEARCH 3 (May 2013), available at <http://www.medicaid.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Downloads/HH-IRC-Collaborative-5-13.pdf>. We note that some entities have had some success using a Shared Care Manager model. See AIMS Center, University of Washington, Psychiatry & Behavioral Sciences, Division of Integrated Care & Public Health, "Care Manager," <http://aims.uw.edu/collaborative-care/team-structure/care-manager> (last visited Mar. 10, 2016). To achieve some

using validated clinical rating scales and systematically adjusts the treatment plan for those patients who are not progressing well.⁴⁸ Patients in the program “had lower healthcare costs than usual care patients in every cost category observed (outpatient and inpatient mental health specialty costs, outpatient and inpatient medical and surgical costs, pharmacy costs, and other outpatient costs).”⁴⁹ Importantly, Mary Butler and colleagues report that although the IMPACT program “was designed for the geriatric population, . . . it has also been effective for the general adult population.”⁵⁰

It is worth emphasizing that the collaborative care management approach was more expensive than usual care in the first year, when the patients actually received the intervention; cost savings did not accrue until the second, third, and fourth years of the four-year study.⁵¹ The IMPACT program cost \$522 per patient during the first year of participation, and achieved net savings of \$3,363 per patient by the fourth year, which is a return on investment of \$6.50 for every \$1.00 spent.⁵² In a 2013 policy brief, Unützer and colleagues “estimate that implementation of collaborative care for the 20 percent of Medicaid members with diagnosed depression could save the Medicaid program approximately \$15 billion per year[,]” which “corresponds to savings in excess of two percent of total annual Medicaid spending.”⁵³ Unützer notes that Medicaid could realize additional savings to the extent that effectively addressing behavioral health issues enables enrollees to join or return to the workforce.⁵⁴

efficiencies, a paraprofessional, such as a medical assistant or community health specialist, “is paired with a licensed behavioral health provider. The paraprofessional performs some of the care manager tasks (except those that are out of their scope of practice, like psychotherapy) and the licensed provider performs the remaining tasks.” *Id.* The ability to use paraprofessionals as Shared Care Managers in New Jersey, however, likely depends on whether and how these individuals would be reimbursed for their services. See Part IV(B) & (C), *infra*.

⁴⁸ UNÜTZER ET AL., THE COLLABORATIVE CARE MODEL, *supra* note 47, at 3. Mary Butler and colleagues have noted that the improvements seen as a result of interventions like this could result from the addition of staff and the adoption of a systematic approach to care, and not from integration *per se*. They argue that “[t]he failure to find a strong link between the integration level and outcomes suggests a need to pay more attention to [the quality of the clinician/patient relationship] as an alternative hypothesis.” BUTLER ET AL., *supra* note 35, at 168. They cite evidence suggesting that “consistent use of evidence-based and/or outcome changing interventions for medical patients with comorbid psychiatric conditions (such as depression) will show superior results to usual care.” *Id.*

⁴⁹ Unützer *et al.*, *Long-Term Cost Effects*, *supra* note 46, at 98.

⁵⁰ BUTLER ET AL., *supra* note 35, at 3.

⁵¹ Unützer *et al.*, *Long-Term Cost Effects*, *supra* note 46, at 99. See also Simon Gilbody, Peter Bower & Paula Witty, *Costs and Consequences of Enhanced Primary Care for Depression: Systematic Review of Randomised Economic Evaluations*, 189 BR. J. OF PSYCHIATRY 297, 305 (2006) (“Enhancements of care, such as case management and collaborative care, mostly produce improved outcomes but are associated with increased direct healthcare costs over the short term[.]”).

⁵² UNÜTZER ET AL., THE COLLABORATIVE CARE MODEL, *supra* note 47, at 6. Somatizers, “[p]eople who experience and express the pain in their life as physical pain[.]” can also be added to the list. Blount *et al.*, *supra* note 36, at 292. Per Blount, “[c]onsultation by psychiatrists or other behavioral health practitioners to the primary care doctor and targeted programs for somatizers that are part of a primary care practice have been shown to pay for themselves and reduce overall medical costs[.]” *Id.* In addition, such programs greatly reduce physician frustration. *Id.*

⁵³ UNÜTZER ET AL., THE COLLABORATIVE CARE MODEL, *supra* note 47, at 6.

⁵⁴ *Id.*

Unützer reports that costs savings similar to those achieved by the IMPACT program with patients with depression “have been identified in collaborative care studies that included patients with depression and diabetes and patients with severe anxiety (panic disorder), as well as in medical collaborative care programs for patients with serious mental illnesses.”⁵⁵ There is also data “from large integrated health care systems, including Kaiser Permanente and Intermountain Healthcare[,]” which “have implemented collaborative care programs and realized substantial cost savings.”⁵⁶

Integrated care can also be cost-effective when targeted at patients with physical health issues. In a review article published in 2007, Alexander Blount and his colleagues write that “[s]creening for mental disorders and providing treatment in populations with as diverse medical problems as chest pain and hip fracture more than pays for the mental health treatment, often by a factor of four or more[.]”⁵⁷ Blount also notes that “[b]ehavioral health services targeted to chronic pain patients reach enough people and make enough difference in reduced utilization of medical services to more than pay for the cost of the behavioral health services[.]”⁵⁸

Blount concludes that “[b]etter identification of behavioral health needs and better targeting of care to those needs, particularly via multidisciplinary collaborative care, lead to lowered overall medical cost in many cases[.]”⁵⁹ Blount goes on to specify that “[c]are management by mental health providers (social workers, psychologists, or psychiatrically trained nurses) and consultation to physicians by psychiatrists or psychologists are the methods that currently have the most evidence supporting their effectiveness and cost-effectiveness[.]”⁶⁰

D. Barriers to Integrated Care

A survey conducted in 2008 by Roger Kathol and colleagues of thirteen nationally-recognized sites attempting to integrate behavioral and physical health care found that “[t]he main barrier to sustainability was financial.”⁶¹ While the specific rules governing reimbursement vary from payer to payer, the medical and other literature addressing behavioral and physical health integration includes many common financial barriers. Start-up costs, such as costs associated with hiring new staff members or making arrangements to host another organization’s staff members, training new and existing staff members, developing new processes and

⁵⁵ *Id.*

⁵⁶ *Id.*

⁵⁷ Blount, *et al.*, *supra* note 36, at 292.

⁵⁸ *Id.*

⁵⁹ *Id.*

⁶⁰ *Id.*

⁶¹ Roger G. Kathol, Mary Butler, Donna D. McAlpine & Robert L. Kane, *Barriers to Physical and Mental Condition Integrated Service Delivery*, 72 *PSYCHOSOMATIC MED.* 511, 515 (2010).

workflows, retrofitting billing and other systems, and making any necessary physical space modifications, can be high.⁶²

Provider organizations confront low reimbursement rates and complicated reimbursement rules. Mental health care is often “carved out” from physical health care and governed by different rules, policies, and procedures. Kathol reports that two of the most commonly-cited barriers to integration were “problems coding for mental condition services in the nonpsychiatric setting” and “not knowing who[m] to bill for services delivered (medical or behavioral payers)[.]”⁶³ Further complicating matters, the applicable rules, policies, and procedures vary from payer to payer. Finally, billing is often made more difficult by complex and inconsistent rules about which types of providers can bill for which types of care.⁶⁴

Payers may decline to reimburse providers for activities that are fundamental to integrated care provision, but which do not constitute traditional medical care or therapy. These activities include screening for behavioral and physical health care needs, care coordination, case management, patient monitoring, consultations, team meetings and other communication between providers, and in-person and telephone consultations with patients.⁶⁵

Payers may also decline to reimburse providers for two services provided on the same day. Among other things, this makes it difficult for providers to do a “warm hand-off” from a behavioral health provider to a physical health provider or vice versa. Blount explains that this is problematic because many patients will not make or keep an appointment to see a behavioral health care provider at another time.⁶⁶ Prior authorization requirements can also be a barrier to “warm hand-offs” and timely care provision,⁶⁷ as can an inability to bill for short amounts of time.⁶⁸

Many models of behavioral and physical health integration rely on the services of a case manager but face difficulty securing adequate reimbursement for the case manager’s services.

⁶² MARGARET HOUY & MICHAEL BAILIT, BARRIERS TO BEHAVIORAL AND PHYSICAL HEALTH INTEGRATION IN MASSACHUSETTS, BLUE CROSS BLUE SHIELD FOUNDATION MASSACHUSETTS 1, 18019 (2015); THE COLORADO HEALTH FOUNDATION, REPORT: THE COLORADO BLUEPRINT FOR PROMOTING INTEGRATED CARE SUSTAINABLY 24 (2012) (hereinafter “COLORADO REPORT”).

⁶³ Kathol *et al.*, *supra* note 61, at 514-15. *See also* BUTLER ET AL., *supra* note 35, at 33 (explaining that carving out behavioral health can mean that a benefit design “prohibit[s] reimbursement for mental health services by primary care physicians (except usually the initial visit), and there is no financial mechanism for coordination across physicians who are contracted on separate panels.”).

⁶⁴ Levey *et al.*, *supra* note 15, at 366. *See also* COLORADO REPORT, *supra* note 62, at 26.

⁶⁵ BUTLER ET AL., *supra* note 35, at 3, 33-37. *See also* HOUY & BAILIT, *supra* note 62, at 14 (explaining that while MassHealth does reimburse “for the time that the care manager is in direct communications with a provider or with the patient or patient’s family[,]” the “[p]ayments do not cover the array of other tasks that are needed to provide integrated care, such as making referrals, informal communication with the office staff, and care and service coordination with social service agencies.”).

⁶⁶ Blount *et al.*, *supra* note 36, at 294.

⁶⁷ HOUY & BAILIT, *supra* note 62, at 1.

⁶⁸ Blount *et al.*, *supra* note 36, at 294 (arguing that “[b]ecause contacts in primary care can be very brief, units of billing as short as 10 min should be allowed”).

Similarly, not all payers cover lay people serving as community health workers, health coaches, or peer specialists. Nor do all payers permit primary care physicians to bill for mental health services⁶⁹ or cover telehealth services, which are one way for primary care providers to secure expert psychiatric consultation.

Finally, payers may decline to allow reimbursement for health and behavior (HAB or HABI) billing codes, which are used “when working with patients and their families on behavioral health components of physical conditions, such as smoking cessation therapy for chronic obstructive pulmonary disease patients or weight management for diabetics[.]”⁷⁰ These codes allow providers to treat the behavioral health needs of patients who do not have a behavioral health diagnosis. Similarly, some payers do not pay for Screening, Brief Intervention, Referral, and Treatment (SBIRT) billing codes, which reimburse primary care providers for treatment offered to patients at risk of substance abuse.⁷¹

While less has been written about state licensing requirements, they can also be barriers to integration. In a recent policy brief on barriers to integration in Massachusetts, Margaret Houy and Michael Bailit focused on, among other things, the separate licensing standards that govern outpatient primary care clinics, outpatient mental health clinics, and substance abuse treatment programs. Houy and Bailit write that “each set of regulations is prescriptive as to facility, program content, and staffing requirements and appears to have been written at a time when it was the norm that the programs would be operated separately and independently, even if the services are located in the same clinic space.”⁷² This, in turn, means that “the requirements conflict, overlap, and duplicate one another, making it very difficult to navigate among the various requirements to create an integrated program.”⁷³ The situation is further complicated by the fact that there are “varying interpretations” of what the requirements are.⁷⁴

Houy and Bailit also complain that there is no common understanding in Massachusetts regarding what triggers the licensing requirement. The licensing process is burdensome, and licenses must be renewed every two years. Writing specifically about the substance abuse regulations’ documentation requirements, Houy and Bailit make the broadly applicable observation that “the regulations do not envision an integration model built on warm hand-offs and quick initial assessments.”⁷⁵

Notwithstanding the many documented advantages of integrated care, barriers to widespread implementation persist. In addition to the barriers related to licensure and

⁶⁹ BUTLER ET AL., *supra* note 35, at 34.

⁷⁰ HOUY & BAILIT, *supra* note 6276, at 16.

⁷¹ TAKACH ET AL., *supra* note , at 3.

⁷² *Id.* at 4.

⁷³ *Id.*

⁷⁴ *Id.*

⁷⁵ *Id.* at 7.

reimbursement that are the focus of this Report, proponents of reform must confront “challenges around patient engagement, creating a unified organizational and team culture, organizational resistance to change, and lack of interoperability among electronic medical records[.]”⁷⁶As Blount explains, “the clinical routines of integrated primary care are substantially different from those of separated primary care and specialty mental health[.]”⁷⁷ Primary care physicians and mental health professionals providing traditional therapy services may find it difficult to carve out time for the many relatively brief interactions that integrated care may necessitate.

Lingering misconceptions about integration are also a barrier. Manderscheid and Kathol point to “the perception that a separate BH service delivery system is required for managing difficulties with cognitions, emotions, and behaviors[, the belief] that independent payment systems are needed to maximize value and ensure adequate control of and support for delivery of BH services[, and the fact that] considerable stigma surrounds BH conditions and their treatment, making it difficult for representatives of BH and primary and specialty medical care to have the necessary dialogue that would facilitate service integration.”⁷⁸

III. Facility Licensing Barriers to Integration in New Jersey

Our discussions with stakeholders throughout the State reveal many real and perceived barriers to behavioral health integration. After discussions with regulators, we were able to conclude that some of the barriers providers described do, in fact, inhibit integration. We also were able to determine that some of the problems brought to our attention did not relate to the structure of New Jersey’s current licensure regulations, but instead reflect confusion and ambiguity in current regulatory practice. In this Part, we describe and analyze the current regulatory landscape. In Subpart A, we review New Jersey’s statutory and regulatory provisions governing licensure of ACFs, MHPs, outpatient substance abuse treatment facilities, and hospital-based outpatient programs. In Subpart B, we address a number of the barriers to integration that were reported to us, both to correct misconceptions and to point out where regulatory practice unnecessarily frustrates integration. Our aim is to narrow the issues and focus on genuine regulatory barriers to integration taken up in Part V below.

A. Overview of New Jersey Regulatory Law Applicable to Outpatient Primary Physical and Behavioral Health Care Services

State licensure is a critical initial hurdle that health care facilities must satisfy on their path to integration. The Health Care Facilities Planning Act provides that no health care service or

⁷⁶ HOUY & BAILIT, *supra* note 6276.

⁷⁷ Blount *et al.*, *supra* note 36, at 294.

⁷⁸ Manderscheid & Kathol, *supra* note 4, at 61.

health care facility may operate in New Jersey – or be reimbursed for services provided⁷⁹ - without a license that has been issued by the State that specifies “the kind or kinds of health care services the facility is authorized to provide.”⁸⁰ This statute applies, among other things, to outpatient services provided at public health centers and outpatient clinics,⁸¹ but it generally does not apply to health care services provided by physicians in private practice.⁸²

In particular, the New Jersey DOH licenses health care facilities that provide ambulatory care services as ACFs.⁸³ An ACF is “a health care facility or a distinct part of a health care facility in which preventive, diagnostic, and treatment services are provided to persons who come to the facility to receive services and depart from the facility on the same day.”⁸⁴ All ACFs must comply with the licensing requirements set forth in N.J.A.C. §§ 8:43A-1 through 11 and 13 through 19.⁸⁵ Other regulatory requirements apply depending on the services that an ACF provides. Those providing primary care services, for example, also must comply with N.J.A.C. § 8:43A-23.⁸⁶

DOH also licenses hospital facilities,⁸⁷ which are required to provide outpatient services “on a regular and continuing basis . . . in those services provided on an in-patient basis.”⁸⁸ Psychiatric hospitals are required to provide psychiatric services, but general hospitals are not.⁸⁹ As a result, general hospitals are not required to provide outpatient behavioral health services unless they provide inpatient behavioral health services. All general hospitals must “provide no less than out-patient services in medicine and surgery.”⁹⁰ The license issued by DOH to the hospital specifies the scope of services that the hospital is authorized to offer to the public.⁹¹

While DOH generally licenses health care facilities and services in New Jersey,⁹² the Health Care Facilities Planning Act recognizes an exception: a MHP that is licensed by the State Department of Human Services pursuant to the Community Mental Health Services Act (CMHSA)⁹³ “shall be deemed to satisfy the requirements for licensure of a health care facility by the Department of Health.”⁹⁴ The CMHSA defines a MHP as “a program of mental health services

⁷⁹ N.J.S.A. § 26:2H-18(a).

⁸⁰ *Id.* § 26:2H-12(a).

⁸¹ *See id.* § 26:2H-2(a).

⁸² *See id.* § 26:2H-2(b). The State Board of Medical Examiners generally regulates the private practice of medicine in New Jersey.

⁸³ *See* N.J.A.C. § 8:43A-1.1 *et seq.*

⁸⁴ *Id.* § 8:43A-1.3.

⁸⁵ *Id.* § 8:43A-32.1.

⁸⁶ *See id.* §§ 8:43A-12, 20-30, 32.

⁸⁷ *See* N.J.S.A. § 26:2H-12(a); N.J.A.C. § 8:43G-1.1 *et seq.*

⁸⁸ *See* N.J.A.C. § 8:43G-5.21(a); *see also id.* § 8:43G-2.12(a)(19).

⁸⁹ *See id.* § 8:43G-2.12. Of course many general hospitals do provide psychiatric and other mental health services even though they are not required to do so.

⁹⁰ *See id.* § 8:43G-5.21(b).

⁹¹ *See* N.J.A.C. § 8:43G-1.2.

⁹² *See generally* N.J.S.A. §§ 26:2H-1; 26:2H-2(i) & (j); 26:2H-5(b).

⁹³ *See id.* § 30:9A-18 *et al.*

⁹⁴ *See id.* § 26:2H-12a.

which is subject to regulations adopted by the commissioner [of DHS]. The program may be public or private, hospital-based or non-hospital-based, incorporated or unincorporated, and for profit or nonprofit.”⁹⁵

The CMHSA and its implementing regulations require a license to conduct, maintain, or operate a MHP.⁹⁶ DHS has promulgated regulations that establish the licensing requirements for MHPs, which are found at N.J.A.C. § 190-1.1 *et seq.*⁹⁷ Programs specify on their application to DHS for licensure which mental health services they seek to provide⁹⁸ - youth partial care services,⁹⁹ outpatient services,¹⁰⁰ partial care services,¹⁰¹ youth case management,¹⁰² intensive family support services,¹⁰³ and programs of assertive community treatment (PACT).¹⁰⁴ Different licensing standards apply depending on the specific mental health services that the MHP offers.¹⁰⁵ Licensing requirements also vary depending on whether the MHP has a purchase of service contract¹⁰⁶ or an affiliation agreement¹⁰⁷ with the Division of Mental Health and Addiction Services (DMHAS).¹⁰⁸ The regulations identify certain licensing standards as Level I,¹⁰⁹ which are the “standards which relate most directly to client rights, safety, and staffing” and “with which mental health programs must be in full compliance in order to be granted or to continue to receive a Department license.”¹¹⁰ DHS’s MHP licensing requirements do not apply to licensed independent practitioners, including group practices.¹¹¹

MHPs that provide outpatient services must comply with standards set forth in N.J.A.C. § 10:37E.¹¹² Outpatient services are defined as “mental health services provided in a community setting to clients who possess a psychiatric diagnosis, including clients who are seriously and persistently mentally ill but excluding substance abuse and developmental disability unless

⁹⁵ *Id.* § 30:9A-18.

⁹⁶ *See id.* § 30:9A-19; N.J.A.C. § 10:190-1.1(b).

⁹⁷ N.J.A.C. § 10:190-1.1 *et seq.*

⁹⁸ *Id.* § 10:190-1.4.

⁹⁹ *See id.* § 10:191.

¹⁰⁰ *See id.* § 10:37E.

¹⁰¹ *See id.* § 10:37F.

¹⁰² *See id.* § 10:37H.

¹⁰³ *See id.* § 10:37I.

¹⁰⁴ *See id.* § 10:37J.

¹⁰⁵ *Id.* §§ 10:190-1.3, 1.6(b).

¹⁰⁶ *See id.* 10:190-1.2 (“Purchase of service contract’ means a contract between the [Division of Mental Health and Addiction Services within the Department of Human Services] and a provider agency through which the Division pays for mental health services on behalf of eligible consumers.”).

¹⁰⁷ *See id.* (“Affiliation agreement’ means a signed agreement between the mental health program and the [Division of Mental Health and Addiction Services within the Department of Human Services] wherein the program agrees to comply with applicable licensing regulations and applicable program standards.”).

¹⁰⁸ *See id.* § 10:190-1.6(c).

¹⁰⁹ *See id.* § 10:190-1.3.

¹¹⁰ *Id.* § 10:190-1.2.

¹¹¹ *See id.* § 190-1.1(b)(4)(ii).

¹¹² *See id.* § 10:190-1.6(b)(2).

accompanied by treatable symptoms of mental illness. Periodic therapy, counseling, and supportive services are generally provided onsite at the provider agency for relatively brief sessions (between 30 minutes and two hours). Services may be provided individually, in group, or in family sessions.”¹¹³

In addition to licensing MHPs, DHS also licenses outpatient substance abuse treatment facilities (SAs).¹¹⁴ Chapter 161B of Title 10 in the New Jersey Administrative Code establishes licensure standards for SAs that apply:

to all substance (alcohol and drug) abuse treatment facilities that provide outpatient substance abuse treatment services to adults and juveniles, including: outpatient, intensive outpatient, partial care outpatient detoxification and opioid treatment which includes opioid maintenance and opioid detoxification. Outpatient substance abuse treatment facilities provide diagnostic and treatment services to persons who present at the facility to receive services and depart from the facility on the same day.¹¹⁵

A facility may not operate as a SA without a license issued by DHS,¹¹⁶ and the license must specify which of the five specific categories of services listed in N.J.A.C. § 10:161B-2.1(j) the facility provides: partial care; intensive outpatient; outpatient; outpatient detoxification; or opioid treatment, which may include opioid detoxification and opioid maintenance.¹¹⁷

Regulators from DOH and DHS enjoy considerable discretion to waive licensing requirements in appropriate cases. The Commissioner of DOH, or his/her designee, has discretion to waive provisions of the DOH rules, upon written request, if such waiver would not endanger the life, safety, or health of patients or the public.¹¹⁸

¹¹³ *Id.* § 10:37E-1.2. Note, however, as discussed below, *see infra* notes 258 & 312 and accompanying text, that New Jersey Medicaid presently does not reimburse FQHCs for group therapy.

¹¹⁴ *See* N.J.A.C. § 10:161B-1.1 *et seq.* Note that although the regulations continue to refer to the Division of Addiction Services (DAS), “[t]he State of New Jersey’s Fiscal Year 2011 Budget formally merged the Division of Mental Health Services (DMHS) and the Division of Addiction Services (DAS) into the Division of Mental Health and Addiction Services (DMHAS).” State of N.J., Dep’t of Human Servcs., Div. of Mental Health & Addiction Servcs., <http://www.nj.gov/humanservices/dmhas/home/> (last visited June 1, 2015). *See generally* N.J. Dep’t of Human Services, Division of Addiction Servcs., <https://www.nj-das.net/UI/Overview.aspx> (last visited May 29, 2015) (“The Division of Addiction Services (DAS) was created by law in 1989 (P.L. 1989, c. 51; N.J.S.A. 26:2BB-5 and 6), combining the previously created Division of Narcotic and Drug Abuse Control (P.L. 1969, c. 152; N.J.S.A. 26:2G-1), and Division of Alcoholism (P.L. 1975, c. 305; N.J.S.A. 26:2B-9), both in the Department of Health and Senior Services. Effective April 5, 2004, DAS was transferred from the Department of Health and Senior Services to the Department of Human Services by Reorganization Plan 002-2004 (36 N.J.R. 1149(a)).”).

¹¹⁵ N.J.A.C. § 10:161B-1.1(a); *see also id.* § 10:161B-1.3 (defining SA).

¹¹⁶ *See id.* § 10:161B-161B-2.1(a).

¹¹⁷ *See id.* §§ 10:161B-161B-2.1(j)-(k).

¹¹⁸ *See id.* § 8:43A-2.9(a); §§ 8:43A-2.9(b)-(c), 8:43A-32.3; § 43E-5.6(a); § 8:43G-2.8(a).

DHS's "Office of Licensing (OOL) licenses all community mental health programs and addiction treatment facilities and programs. OOL staff consults with [DHS's Division of Mental Health and Addiction Services (DMHAS)] staff, including when reviewing and deciding waiver requests affecting mental health and addiction treatment licenses."¹¹⁹ With respect to MHPs, DHS has discretion to consider waivers of specific rules if, "in the opinion of the Director of the Office of Licensing, in consultation with the Assistant Commissioner for Mental Health Services, or their designees, such waiver is justified as outlined [in the regulations], would not impair the effective and efficient provision of mental health services within the system of care, and would not endanger or adversely affect the life, safety or welfare of clients."¹²⁰

An applicant or current SA licensee may seek a waiver of one or more provisions of the SA licensing requirements "provided that the applicant or licensee demonstrates that compliance represents an unreasonable hardship for the applicant or licensee, and such waiver is determined by [DMHAS] to be consistent with the general purpose and intent of its enabling statute and these rules; is consistent with prevailing [DMHAS] public policy; and would not otherwise jeopardize recovery, endanger the life, safety, health or welfare of the client populations to be served, their families, personnel who work or would work at the program, or the public."¹²¹

As this Report was going to press, DOH released the Shared Space Waiver, invoking its waiver authority, to relax and clarify the clinical space requirements for integrated care in licensed primary care settings.¹²²

¹¹⁹ *Id.* § 10-30-1.1(h).

¹²⁰ *Id.* § 10:190-1.9(a).

¹²¹ *Id.* § 10:161B-2.13. DMHAS also shall approve a written request to license a new or innovative program, in whole or in part, if it "does not present significant risk of harm to the life, safety, health or well-being of the clients, and the applicant demonstrates that the program is reasonably within the bounds of accepted practice." *Id.* § 10:161B-2.5(a)(1). DMHAS also may fashion a conditional license with specific conditions and standards on licensure of a SA because "the purposes and intent of the proposed program are outside the scope of a regular license[;] . . . [DMHAS] determines that it is in the best interest of the clients benefiting from the treatment program in question and in order to preserve and/or improve the proper functioning of the program[;] . . . [there are] contingencies and/or special program needs that can be addressed by the applicant and monitored by [DMHAS], as agreed between [DMHAS] and the applicant, with the safety and well being of the clients and staff of the program as the overriding priority;" or the program provides a type or category of service not itemized in the regulations. *Id.* § 10:161B-2.7. The SA licensing requirements all apply in addition to the special terms set forth in the conditional license, although DMHAS can specifically identify standards that will not apply under the conditional license. *See id.* § 10:161B-2.7(a).

¹²² *See* Shared Space Waiver, *supra* note 9 & accompanying text; Part III(B)(9)(a) *infra*.

B. Analyzing Specific Perceived Licensing Barriers to Integration under New Jersey Law

1. May a primary care ACF provide mental health services without also being licensed as a MHP?¹²³

Many FQHCs, which are a type of ACF, have been providing and billing for a limited range of behavioral health services using a set of codes provided by New Jersey Medicaid even though they are not licensed MHPs by DHS. There have been draft regulatory proposals circulated to formalize this arrangement, but to date they have not been formally proposed. Some FQHCs have reported an unexplained increased number of denials in recent months when they have submitted bills for reimbursement using these codes. Others would like to expand the services that they offer, but there is considerable uncertainty regarding whether they may. They report that this uncertainty has been an impediment to integration, and FQHCs and other ACFs seek clarity regarding the scope of services they may offer without needing a MHP license as well.

DOH requires an applicant seeking licensure as an ACF to indicate on its application to DOH the specific health care services that it wants to provide,¹²⁴ and if an ACF seeks to offer additional services after its initial licensure, it must identify those services on its annual licensure renewal application.¹²⁵ DOH regulations state that an ACF may only provide “those services for which it is licensed or authorized to provide by [DOH].”¹²⁶

DOH’s regulations define ambulatory care services to include, but not be limited to: primary care;¹²⁷ hospital outpatient; ambulatory surgery; family practice; family planning;

¹²³ Because the MHP regulations do not apply to individual or group practices, an individual behavioral health practitioner may provide behavioral health services in an ACF without obtaining a license from DHS. But the individual practitioner will bill for these services under his or her professional license; the facility may not seek reimbursement for these services. This Subpart is focused on facilities that seek to offer and seek reimbursement for behavioral health services. We did hear frequent concerns that reimbursement rates paid to individual practitioners were too low to make the individual practitioner billing model of integration sustainable.

¹²⁴ N.J.A.C. § 8:43A-2.3(c).

¹²⁵ *Id.* § 8:43A-2.3(d).

¹²⁶ *Id.* § 8:43A-2.3(b).

¹²⁷ DOH’s ACF regulations provide the following definition of primary care:

"Primary care" means the provision by a health care facility of preventive, diagnostic, treatment, management, and reassessment services to individuals with acute or chronic illness. The term is used in reference to facilities providing family practice, general internal medicine, general pediatrics, obstetrics, gynecology, and/or clinical preventive services, including community health centers providing comprehensive primary care. Comprehensive primary care may include the provision of sick and well care to all age groups, from perinatal and pediatric care to geriatric care. Primary care is further characterized by the fact that it represents the initial point of contact between an individual and the health care system, by the assumption of responsibility for the person regardless of the presence or absence of disease, by the ongoing responsibility for

outpatient drug abuse treatment; chronic dialysis; computerized axial tomography; magnetic resonance imaging; extracorporeal shock wave lithotripsy; orthotripsy; radiological services; megavoltage radiation oncology; positron emission tomography; abortion; comprehensive outpatient rehabilitation; birth center; sleep center; and PACE organization.¹²⁸

Notably, mental health services are not among the health care services itemized in DOH's ACF regulations. ACFs may directly provide social work services,¹²⁹ but they must refer "[a]ll patients who have been identified as needing, or who have requested, other counseling services such as, but not limited to, . . . psychological . . . counseling," to appropriate providers.¹³⁰

But DOH's regulations leave room for the Commissioner of Health to approve an ACF to provide services beyond those itemized in the ACF regulations.¹³¹ If an application seeks licensure for a health care service for which DOH has not adopted specific licensing standards, "the Commissioner [of DOH] may impose additional requirements [in addition to those set forth in N.J.A.C. 8:43A-1 through 11 and 13 through 19]¹³² . . . to protect the health of the inhabitants of the State."¹³³ Thus, DOH has discretion, without statutory or regulatory change, to permit primary care ACFs to offer mental health services by adding to the list of services an ACF may provide.¹³⁴

DOH's statutes and regulations, however, cannot be viewed in isolation. It is important to consider what DHS's statutes and regulations say about the licensure of facilities providing mental health services in outpatient settings, since DHS is charged by statute with licensing MHPs.

coordination of medical care for the person, by its family-centeredness, and by its community orientation.

Id. § 8:43A-1.3.

¹²⁸ *Id.* §§ 8:43A-1.1, 8:43A-2.2(b) & (e).

¹²⁹ *See id.* § 8:43A-10.2 (cross-referencing N.J.S.A. 45:15BB-1 *et seq.*).

¹³⁰ N.J.A.C. § 8:43A-10.1(a). *See also id.* § 8:43A-1.3 ("'Counseling' means provision of information intended to direct the behavior of a patient. Counseling services include, but are not limited to, dietary counseling, social work, and/or drug counseling services.").

¹³¹ *See id.* §§ 8:43A-2.2(e); 8:43A-32.2.

¹³² *Id.* § 8:43A-32.1.

¹³³ *Id.* § 8:43A-32.2(a). *See also id.* § 8:43A-2.7 ("A conditional license may be issued to a health care facility providing a type or category of health care service neither listed in N.J.A.C. 8:43A-2.3(a) nor otherwise addressed by this chapter. The facility shall comply with the standards set forth as a condition of the license."); *id.* § 8:43E-5.4 (recognizing that DOH may issue a conditional license "to a health care facility providing a type of category of health care service neither listed nor otherwise addressed in the applicable licensure chapter for that type of facility").

¹³⁴ Representatives from DOH agreed that the agency has discretion to add mental health to the list of services an ACF may perform. But they also expressed a reluctance to exercise this option because the agency does not have any regulations that address behavioral health licensing, so they feel that they are not prepared to regulate facilities offering mental health services.

DHS's statutes and regulations seem to permit DOH to license mental health services, although they are not a model of clarity. Although the Community Mental Health Services Act prohibits the operation of a MHP unless it is licensed by DHS or the Commissioner of Children and Families and the MHP has a purchase of service contract or affiliation agreement with DMHAS or the Department of Children and Families,¹³⁵ the statute also includes important limiting principles. Nothing in the statute shall be construed to limit the authority of DOH "with respect to the licensure of a health care facility pursuant to P.L. 1971, c.136 (C.26:2H-1 et seq.), regardless of whether the facility operates a separate psychiatric unit or service."¹³⁶ Nor shall the statute be construed to require DHS to license a health care facility licensed by DOH.¹³⁷ These provisions suggest that DHS's MHP licensing requirements do not preclude DOH from licensing health care facilities that provide mental health services.

DHS's regulations similarly suggest that DOH may regulate mental health services. N.J.A.C. § 10:190-1.1(b) provides that "[n]o mental health program shall operate unless it is licensed by the Commissioner of the Department of Human Services as a mental health program and has a purchase of service contract or an affiliation agreement with the Division of Mental Health and Addiction Services, *or is licensed by the Commissioner of the Department of Health as a health care facility.*"¹³⁸ This DHS regulation suggests that DOH may license a health care facility as a MHP as an alternative to the facility needing to be licensed by DHS. In the same vein, DHS's regulations go on to specify in Section 190-1.1(b)(4)(vi) that its licensing requirements for MHPs do not apply to "[a] mental health program licensed by the [DOH] as a health care facility, provided that each site of such program holds a separate [DOH] license or is specified on the main facility's [DOH] license."¹³⁹

But DHS's MHP regulations also define a MHP in § 10:190-1.1(b)(2) as "a program of mental health services not licensed by [DOH] as a health care facility."¹⁴⁰ It is confusing that DHS's regulations both refer to programs that DOH may license as "mental health programs" and then define "mental health program" to exclude programs of mental health services that are licensed by DOH.

DHS's regulatory intent seems to recognize DOH's authority to license health care facilities that provide mental health services. A possible way to reconcile the confusing regulatory language is to recognize that "mental health program" is a term of art under New Jersey law that refers to programs providing mental health services that are licensed by DHS.¹⁴¹

¹³⁵ See N.J.S.A. § 30:9A-19(a).

¹³⁶ See *id.* § 30:9A-20(a).

¹³⁷ See *id.* § 30:9A-20(b).

¹³⁸ N.J.A.C. § 10:190-1.1(b) (emphasis added).

¹³⁹ *Id.* § 10:190-1.1(b)(4)(vi).

¹⁴⁰ *Id.* § 10:190-1.1(b)(2).

¹⁴¹ See N.J.S.A. § 30:9A-18 (defining "mental health program" to mean "a program of mental health services which is subject to regulations adopted by the commissioner [of DHS]").

As the statute provides, mental health *programs* require DHS licensure,¹⁴² but health care *facilities* licensed by DOH do not also need to be licensed by DHS to provide some mental health services.¹⁴³

For example, representatives of DHS acknowledged to us that DOH licenses facilities offering limited mental health services, such as screening, brief intervention, and limited counseling and medication management without also requiring a MHP license from DHS. FQHCs, in particular, may provide the limited set of behavioral health services according to the unwritten agreement without needing to obtain a separate MHP license. But if an ACF, whether an FQHC or other type of ACF, wants to offer a full complement of psychiatric services, such as ongoing psychotherapy or group therapy, it needs a MHP license.

It would be helpful for DHS to clarify its regulatory language to eliminate the internal inconsistencies and for both agencies to clarify the extent to which DOH may license facilities offering mental health services without also requiring a MHP license from DHS.¹⁴⁴ This clarification could, for example, be issued as a memorandum providing information and guidance, as did the recently-released Shared Space Waiver,¹⁴⁵ and could inform regulated entities of the agencies' official positions with respect to the threshold at which dual licensure is required. Such clarification could remedy the currently-prevalent confusion among regulated providers of services, and may clarify where providers and the regulating agencies have principled, as opposed to apparent, differences.

2. May a primary care ACF licensed by DOH provide outpatient substance abuse treatment services without also having a SA license from DHS?

Although drug abuse treatment services are among the specific health care services listed that ACFs may provide, this term is defined narrowly in DOH's ACF regulations to mean "methadone detoxification, methadone maintenance, and/or drug-free counseling programs."¹⁴⁶ As noted above, while ACFs may directly provide social work services,¹⁴⁷ they generally must refer "[a]ll patients who have been identified as needing, or who have requested, other counseling

¹⁴² See *id.* § 30:9A-19(a).

¹⁴³ See *id.* § 30:9A-20(a)-(b).

¹⁴⁴ If DOH may license ACFs that provide mental health services even if DHS is not licensing them as MHPs, DOH will need to consider if it should impose additional regulatory requirements as conditions on licensure. See N.J.A.C. § 8:43A-32.2(a); see also *id.* § 8:43A-2.7 ("A conditional license may be issued to a health care facility providing a type or category of health care service neither listed in N.J.A.C. 8:43A-2.3(a) nor otherwise addressed by this chapter. The facility shall comply with the standards set forth as a condition of the license."). DHS's MHP regulations, for example, contain a number of requirements that are specific to the particular mental health services being offered that DOH may want to consider adopting in appropriate situations. See, e.g., *id.* § 10:190-1.6.

If DOH were to add mental health services to the list of services ACFs may provide, it is possible that DHS would not require these facilities to obtain MHP licenses as well, assuming DOH adopts appropriate regulatory standards.

¹⁴⁵ See Shared Space Waiver, *supra* note 9.

¹⁴⁶ N.J.A.C. § 8:43A-1.3.

¹⁴⁷ See *id.* § 8:43A-10.2 (cross-referencing N.J.S.A. 45:15BB-1 *et seq.*).

services such as, but not limited to, . . . psychological . . . and drug abuse counseling” to appropriate providers.¹⁴⁸ But if an ACF provides drug abuse treatment services, then it also must provide drug abuse counseling services in the facility.¹⁴⁹ As discussed above, DOH has discretion to add to its list of services that ACFs may provide.¹⁵⁰

DHS’s SA regulations acknowledge that ACFs may offer outpatient substance abuse treatment services.¹⁵¹ But, as noted in Part III(B)(7) below discussing dual licensure, DHS’s regulations require ACFs that provide outpatient substance abuse assessment, referral and/or treatment services to have a separate SA license.¹⁵² While this may not preclude DOH from exercising its discretion to license substance abuse treatment services, such regulation would have to be in addition to, and not in place of, DHS’s regulation.¹⁵³ It is unclear if DHS ever would exercise its discretion to waive this licensure requirement in its entirety.

3. May a MHP licensed by DHS provide primary physical health services without also obtaining an ACF license from DOH?

We heard from a number of providers that facilities licensed by DHS as MHPs are permitted by DOH to provide up to eight hours of outpatient primary care services per week without an ACF license. To exceed eight hours per week, however, DOH reportedly would require them to be licensed as ACFs as well. We did not identify this so-called “Eight Hour Rule” in DOH or DHS’s statutes or regulations nor in any agency guidance. But representatives of DOH confirmed that this is an unwritten DOH policy that has developed over the years.¹⁵⁴

Standing alone, apart from this unwritten policy, DOH’s governing law requires an ACF license if a health care facility offers preventive, diagnostic, and treatment services, including but not limited to primary care; hospital outpatient;¹⁵⁵ ambulatory surgery; family practice; family planning; outpatient drug abuse treatment; chronic dialysis; computerized axial tomography; magnetic resonance imaging; extracorporeal shock wave lithotripsy; orthotripsy;

¹⁴⁸ N.J.A.C. § 8:43A-10.1(a).

¹⁴⁹ *See id.* § 8:43A-26.5.

¹⁵⁰ *See id.* §§ 8:43A-2.2(e); 8:43A-32.2; *supra* notes 131-134 & accompanying text.

¹⁵¹ N.J.A.C. § 10:161B-1.1(c).

¹⁵² *See infra* notes 183-184 & accompanying text.

¹⁵³ *Cf.* N.J.A.C. § 10:161B-3.2(b) (“If a licensed program provides outpatient substance abuse treatment services in addition to other health care services, the licensee shall comply with the rules in this chapter [concerning DHS’s licensure of SAs] and all other applicable rules.”).

¹⁵⁴ *See also* N.J. Health Home State Plan Amendment, Transmittal No. NJ-14-0005, OMB Control No. 0938-1148, Expiration Oct. 31, 2014, at 18, *reproduced in* N.J. State Plan Under Title XIX of the Social Security Act Medical Assistance Program, Attachment 3, at 334 (“Ultimately, Primary care must be fully or partially co-located within the [Behavioral Health Home]. This can be accomplished by siting a primary care clinic in the BHH or by bringing primary care services into the BHH for up to eight hours of direct service each week.”), *available at* http://www.state.nj.us/humanservices/dmahs/info/state_plan/Attachment3_Services_including_Scope_and_Limitations.pdf (last visited June 9, 2015).

¹⁵⁵ The ACF regulations seem to require ACF licensure for hospital outpatient services even on hospital campuses, although it appears that the DOH does not require such double licensure. *See* Part III(B)(8) *infra*.

radiological services; megavoltage radiation oncology; positron emission tomography; abortion; comprehensive outpatient rehabilitation; birth center; sleep center; and PACE organization -- to individuals who come to the facility to receive services and depart from the facility on the same day.¹⁵⁶ Thus to the extent a MHP seeks to offer these services, it would need to be licensed by DOH¹⁵⁷ unless DOH exercises its discretion to waive its licensing requirements.¹⁵⁸ In any instance where licensure responsibility straddles departmental lines, the interests of inter-departmental comity counsel against a broad exercise of waiver authority without the acquiescence of the other Department.

4. May a MHP licensed by DHS provide outpatient substance abuse treatment services without obtaining a separate SA license from DHS?

As discussed above, DHS's SA regulations require facilities to be licensed as outpatient substance abuse treatment facilities by DHS to provide outpatient substance abuse treatment services.¹⁵⁹ Therefore, a MHP may not offer outpatient substance abuse treatment services without a SA license. According to DHS licensing officials, however, if a patient with a mental health primary diagnosis has a co-occurring substance abuse disorder diagnosis, then a MHP may provide substance abuse treatment services without also being licensed as a SA. But because DHS's MHP regulations exclude substance abuse from the definition of outpatient services, unless the substance abuse is accompanied by treatable symptoms of mental illness,¹⁶⁰ the scope of substance abuse services the MHP may provide is limited.

5. May an outpatient substance abuse treatment facility licensed by DHS provide primary physical health services without also obtaining an ACF license from DOH?

As discussed in Part III(B)(3) above, DOH requires an ACF license if a health care facility offers preventive, diagnostic, and treatment services -- including, but not limited to primary care; hospital outpatient;¹⁶¹ ambulatory surgery; family practice; family planning; outpatient drug abuse treatment; chronic dialysis; computerized axial tomography; magnetic resonance imaging; extracorporeal shock wave lithotripsy; orthotripsy; radiological services; megavoltage radiation

¹⁵⁶ See N.J.A.C. §§ 8:43A-1.3, 2.2, 2.3.

¹⁵⁷ Although a DHS license to a MHP pursuant to N.J.S.A. § 30:9A-18 satisfies DOH's licensure requirements for health care facilities in N.J.S.A. § 26:2H-12, see N.J.S.A. § 26:2H-12(a), a MHP license does not satisfy DOH's ACF licensure requirements in N.J.A.C. § 8:43A-1.1 *et seq.* A MHP that is licensed by DHS does not need a DOH license to satisfy § 26:2H-12. But if that MHP wants to provide ACF services, it still will need to satisfy DOH's ACF licensure requirements.

¹⁵⁸ N.J.A.C. § 8:43A-2.9(a); see also §§ 8:43A-2.9(b)-(c), 8:43A-32.3.

¹⁵⁹ See *supra* notes 114-117, 152-153 & accompanying text; see also N.J.A.C. § 10:161B-3.2(b) ("If a [SA] licensed program provides outpatient substance abuse treatment services in addition to other health care services, the licensee shall comply with the rules in this chapter [governing DMHAS licensure of SAs] and all other applicable rules.").

¹⁶⁰ N.J.A.C. § 10:37E-1.2.

¹⁶¹ See *supra* note 155.

oncology; positron emission tomography; abortion; comprehensive outpatient rehabilitation; birth center; sleep center; and PACE organization -- to individuals who come to the facility to receive services and depart from the facility on the same day.¹⁶² Thus, to the extent a SA seeks to offer these services, it would appear under the current regulations to need an ACF license.¹⁶³

DHS's SA regulations also speak to this issue and are clear that if a SA "provides primary medical care, in addition to any of the . . . five categories of outpatient substance abuse care [specified in the regulations, namely, "partial care; intensive outpatient; outpatient; outpatient detoxification; or opioid treatment which may include opioid detoxification as well as opioid maintenance"¹⁶⁴], a separate primary care license is required and must be obtained from the New Jersey Department of Health"¹⁶⁵

What is less clear is the definitional distinction between primary medical care that requires a separate ACF license and primary medical care services that are part and parcel of providing the five categories of outpatient substance abuse services that SAs are licensed by DHS to provide.

DHS's SA regulations contemplate and in some respects require a measure of integrated care. Specifically, the SA regulations require some facilities to provide elements of primary medical and mental health care in addition to substance abuse treatment. For example, SAs shall provide or arrange for medical and nursing services, including assessment, diagnostic, and treatment; counseling; and vocational, educational and other support services.¹⁶⁶ Treatment is defined broadly to include elements of medical and mental health care: "'Treatment' means a broad range of primary and supportive services, including identification, brief intervention, assessment, diagnosis, counseling, medical services, psychological services, and follow-up, provided to persons with alcohol, tobacco and other problems. . . ."¹⁶⁷ Within three visits of admissions, all SAs are required to complete a drug screen and comprehensive biopsychosocial assessment "using an assessment instrument which assesses medical status, vocational/employment and support, alcohol, tobacco and other drug use, legal status, family/social status, psychiatric status, as well as behavioral risk factors for HIV and hepatitis."¹⁶⁸ The facility's treatment plan then must address each problem identified in the assessment "within the client treatment plan through direct provision or referral to appropriate services."¹⁶⁹ If the assessment reveals that a patient should be referred, the SA must coordinate the referral

¹⁶² See N.J.A.C. §§ 8:43A-1.3, 2.2, 2.3.

¹⁶³ *Id.* § 8:43A-2.9(a); see also §§ 8:43A-2.9(b)-(c), 8:43A-32.3.

¹⁶⁴ *Id.* § 10:161B-2.1(a).

¹⁶⁵ *Id.* § 10:161B-2.1(a). See also *id.* § 10:161B-3.2(b) ("If a licensed [SA] program provides outpatient substance abuse treatment services in addition to other health care services, the licensee shall comply with the rules in this chapter and all other applicable rules.").

¹⁶⁶ See *id.* § 10:161B-3.1(a).

¹⁶⁷ *Id.* § 161B-1.3.

¹⁶⁸ *Id.* § 161B-9.1(a).

¹⁶⁹ *Id.* § 161B-9.2(a)(2).

and provide “interim services at the client's current level of care . . . until the transfer is effected.”¹⁷⁰

DHS’s regulations also require SAs that provide outpatient detoxification services to provide medical services.¹⁷¹ While facilities providing intensive outpatient, outpatient, and partial care substance abuse treatment services are not required to, they may provide medical services either in the facility or through a written agreement.¹⁷² SA programs that provide medical services on-site require physicians to “ensure that medical staff participate as part of the multidisciplinary treatment team”¹⁷³ “Medical services,” however, is not defined in DHS’s outpatient substance abuse treatment facilities regulations, and it is not clear when the provision of medical services to SA patients crosses the line and triggers DHS’s requirement that the SA also obtain an ACF license from DOH.¹⁷⁴

Representatives from DOH expressed the view that screening services and other substance abuse treatment modalities that include aspects of primary health care may be provided within the SA license and do not require a separate ACF license. But if a SA seeks to provide treatment for additional physical conditions, such as diabetes or high blood pressure, the facility would need an ACF license from DOH. DHS representatives similarly expressed the view that SA programs will need to seek licensure from DOH if they want to provide podiatry services to their patients, for example, but they do not need an additional license to provide the screening services required by DHS’s SA regulations.

It would be helpful for DOH and DHS to provide more clarity regarding when services fall within the SA license and when they cross the line and require an ACF license as well.

6. May an outpatient substance abuse treatment facility licensed by DHS provide mental health services without obtaining a separate MHP license from DHS?

DHS’s SA regulations require a comprehensive biopsychosocial assessment that must consider, among other things, the patient's “history of psychological and/or psychiatric treatment, which shall include previous admissions to psychiatric facilities, history of suicidal/homicidal ideation and attempts, outpatient psychiatric treatment, psychotropic medications; and assessments by a psychiatrist or other licensed mental health clinician for clients diagnosed with co-occurring mental health disorders.”¹⁷⁵ The treatment plan then must provide “[i]ntegrated treatment of co-occurring mental health disorders, either on-site or

¹⁷⁰ *Id.* § 161B-9.1(a)(2).

¹⁷¹ *See id.* § 161B-7.1(a)(3).

¹⁷² *See id.* §§ 161B-7.1(a)(1)-(2). Partial care programs are further required to have “written protocols to ensure ready access to psychiatric and medical services.” *Id.* § 161B-7.1(a)(2).

¹⁷³ *Id.* § 10:161B-7.4(b).

¹⁷⁴ *See supra* note 165 & accompanying text.

¹⁷⁵ N.J.A.C. § 10:161B-9.1(b)(4).

through the coordination of treatment services with an appropriate mental health facility.”¹⁷⁶ It does not appear that DHS’s MHP regulations require SAs to obtain a separate MHP license from DHS when they provide these mental health services that are integrated with their substance abuse treatment modalities.

In addition, the MHP licensing regulations state that they do not apply to “specialized services some of which may be similar in nature to [MHPs] but which are designed to primarily address problems of alcoholism or substance abuse disorders”¹⁷⁷ This language suggests that a separate MHP license is not required when a SA provides mental health services as part of an integrated substance abuse treatment plan. It would be helpful for DHS to clarify the scope of this provision so it is clear whether it applies to all SA programs or only particular specialized programs.

As representatives of DHS explained to us, SAs are not required to but may treat co-occurring mental health diagnoses without requiring a separate MHP license as long as the patient’s primary diagnosis is substance use disorder, although we found the clinical and regulatory issues entangled in the designation of a diagnosis as “primary” to be at least murky.¹⁷⁸ SA programs that choose to provide mental health services to clients diagnosed with co-occurring disorders do not need a separate MHP license, but they must comply with various policy and procedure requirements, including staff credentialing and integrated treatment plan requirements.¹⁷⁹

7. May the same health care facility be dual or triple-licensed by DOH and DHS?

Several health care facilities shared their belief that they were ineligible to be licensed by both DOH and DHS for the same physical space. For example, an FQHC told us that, “[a]s an FQHC we were told that we cannot apply for a Mental Health license but [DOH] would not allow us to expand our Behavioral Health services.” Both DOH and DHS, however, agree that it is possible for facilities to be licensed by both agencies.

DOH informed us that a health care facility that has either a MHP license from DHS or an outpatient substance abuse treatment facility license from DHS (or both licenses from DHS) may simultaneously receive an ACF license from DOH, as long as the facility satisfies DOH’s ACF licensing requirements. DOH further confirmed that there is no bar to an FQHC continuing to be licensed as an ACF if it also obtains a MHP license and/or an out-patient substance abuse

¹⁷⁶ *Id.* § 10:161B-(a)(2)(iii). *See also id.* § 10:161B-1.3 (“‘Co-occurring disorder’ means a concurrent substance abuse and mental health disorder as described in the DSM-IV-TR, in which the substance abuse and mental health disorders are both primary.”).

¹⁷⁷ *Id.* § 10:190-(b)(4)(iv).

¹⁷⁸ *See id.* § 10:161B-1.3 (“‘Co-occurring disorder’ means a concurrent substance abuse and mental health disorder as described in the DSM-IV-TR, in which the substance abuse and mental health disorders *are both primary.*”) (emphasis added).

¹⁷⁹ *See id.* § 10:161B-10.4.

treatment facility license from DHS as long as the FQHC “continues to substantially comply with DOH licensing standards, including physical plant.” Representatives from DHS similarly expressed their view that it is possible for facilities to be licensed by both DOH and DHS.

Indeed, a number of DOH and DHS’s regulations seem to recognize that the same facility may be licensed by more than one agency. DOH’s ACF regulations, for example, require an ACF that provides ambulatory care services as well as “other health care services,” to comply with both DOH’s ACF licensing rules and “with the rules for licensure of facilities which provide the other health care services.”¹⁸⁰ DHS’s SA licensing regulations contain a similar provision.¹⁸¹ And as discussed below, DHS’s SA regulations require hospital-based off-site outpatient substance abuse treatment programs to be licensed by DHS in addition to DOH.¹⁸²

As mentioned above, DHS’s SA licensing requirements apply to “primary health care facilities” that are separately licensed by DOH as ACFs pursuant to N.J.A.C. 8:43A when these facilities “offer outpatient substance abuse assessment, referral and/or treatment services or provide any of the modalities of outpatient substance abuse treatment listed in [(N.J.A.C. § 10:161B-1.1(a), namely, “outpatient, intensive outpatient, partial care outpatient detoxification and opioid treatment which includes opioid maintenance and opioid detoxification”).”¹⁸³ This DHS regulation unmistakably specifies that DHS “does require a separate outpatient substance abuse treatment facility license for primary health care facilities; primary health care facilities providing services covered by this chapter shall comply with these standards and shall be licensed, monitored and reviewed by [DHS].”¹⁸⁴

Although DHS’s MHP regulations recognize that either DOH or DHS may license a facility that offers mental health services,¹⁸⁵ as discussed above,¹⁸⁶ they are less clear whether both DOH and DHS may regulate the same facility at the same time. In fact, there are regulatory provisions that seem to preclude dual licensure by these agencies. For example, DHS’s regulations both

¹⁸⁰ *Id.* § 8:43A-3.2(b). *Cf. id.* § 10:66-1.3(b) (“Each independent clinic seeking enrollment in the New Jersey Medicaid and NJ FamilyCare fee-for-service programs shall possess a certificate of need and/or license, if required, from the New Jersey State Department of Health and Senior Services or the Division of Mental Health [and Addiction] Services of the New Jersey Department of Human Services, *or from both agencies*, or possess similar documentation by a comparable agency of the state in which the facility is located.”) (emphasis added); *id.* § 10:66-1.3(b)(1) (“The facility shall provide only those services for which it is licensed or authorized to provide by the New Jersey State Department of Health and Senior Services or the Division of Mental Health [and Addiction] Services of the New Jersey Department of Human Services, *or both*, if applicable, or for which the facility is similarly licensed or authorized by a comparable agency of the state in which the facility is located.”) (emphasis added).

¹⁸¹ *See id.* § 10:161B-3.2(b) (“If a licensed [SA] program provides outpatient substance abuse treatment services in addition to other health care services, the licensee shall comply with the rules in this chapter and all other applicable rules.”).

¹⁸² *See id.* § 10:161B-1.1(b).

¹⁸³ *Id.* § 10:161B-1.1(c).

¹⁸⁴ *Id.*

¹⁸⁵ *See id.* § 10:190-1.1(b).

¹⁸⁶ *See supra* notes 134-145144 & accompanying text.

define a MHP as a program of mental health services *not* licensed by DOH¹⁸⁷ and state that they do not apply to mental health programs licensed by DOH as health care facilities.¹⁸⁸ These provisions seem to rule out dual licensure of a facility by DOH (as an ACF that provides mental health services) and DHS (as a MHP).

But both DOH and DHS believe that dual and even triple licensure is permissible. Indeed, there are MHPs in New Jersey that have applied for and received ACF licenses from DOH. No ACF, however, has successfully obtained a MHP license from DHS although several FQHCs reported to us that they have made attempts to do so. As discussed above, it would be helpful for DHS to amend its MHP regulations to remove the internal inconsistencies and make clear that either agency may regulate programs offering mental health services and that while dual licensure is not required, it is permissible in appropriate cases.¹⁸⁹

The recently-released Shared Space Waiver clarifies this issue to some extent. That document addresses only the integration of services in DOH-licensed ambulatory care facilities, and not DHS-licensed MHPs or outpatient substance use disorder treatment facilities.¹⁹⁰ That said, the Shared Space Waiver clears many (but not all) of the barriers to adding behavioral health services to ACFs such as FQHCs,¹⁹¹ and clarifies that in ACF settings, DOH will permit the provision of behavioral health and primary care services in the same space. The Shared Space Waiver specifically requires that an ACF seeking to offer behavioral health services also obtain a license from DHS.

¹⁸⁷ See N.J.A.C. § 10:190-1.1(b)(2).

¹⁸⁸ See *id.* § 10:190-1.1(b)(4)(vi); *supra* notes 135-144 & accompanying text.

¹⁸⁹ As discussed in more detail in Part V *infra*, many providers with whom we spoke are not interested in obtaining dual or triple licensure. They expressed the view that the additional bureaucratic burdens and uncertainty attendant to having to obtain more than one license would stand as a significant barrier to being able to offer integrated care.

¹⁹⁰ See Shared Space Waiver, *supra* note 9.

¹⁹¹ See *infra*, Part III(B)(9)(a) (discussing what the Shared Space Waiver permits (licensed behavioral health in a licensed ACF) and what it does not address (primary care in MHPs or outpatient substance use disorder treatment facilities and reimbursement issues)).

8. May a hospital-based outpatient program offer both behavioral health and primary care services?¹⁹²

As mentioned above,¹⁹³ DOH licenses hospitals, and each hospital's license specifies the scope of services that it may offer to the public, which may or may not include psychiatric services. A hospital is required to offer outpatient services for the services that it offers on an inpatient basis.

When an outpatient program is located on the same or adjoining grounds as the hospital and is operated under the same management as the hospital, then the outpatient program generally does not require a separate license.¹⁹⁴ The regulations do not define "same or adjoining grounds." DOH policy is to consider a facility on the same or adjoining grounds if it is physically connected to the hospital. This includes situations in which the facility is connected to the hospital through a bridge, tunnel, or other environmentally-controlled area. But if the facility has a different address, even if it is across the street, that is not connected to the hospital, it will not be considered on the hospital's campus.¹⁹⁵

Thus, where a hospital license includes mental health services and the outpatient program is on-site and operated under the hospital's management, it may offer outpatient mental health services under the hospital's license. St. Francis Medical Center, for example, has an outpatient psychiatric clinic that operates on-site and under the hospital's license and management. This clinic is not separately licensed as a MHP by DHS. DHS's regulations expressly provide that a hospital that offers hospital-based outpatient substance abuse treatment services in a designated outpatient unit or facility must also obtain a separate SA license from DHS in addition to the hospital's license.¹⁹⁶ But representatives from DHS informed us that this requirement only applies to off-site programs, as discussed below, and does not apply to hospital-based outpatient substance use treatment programs offered on the hospital's campus.

¹⁹² This Subpart focuses on hospital-based outpatient clinics that are licensed and bill as facilities. It does not address licensed professionals who offer outpatient services through outpatient professional offices that may be part of hospital systems but do not operate under the hospital's license. Because outpatient professional offices bill as providers rather than as facilities, they are regulated by the State Board of Medical Examiners and not separately as facilities licensed by DOH or DHS. Although licensing has not been a barrier to integration for these professionals, they reported several significant operational, workflow, capacity, and reimbursement barriers to realizing integration of primary physical and behavioral health care, including low Medicaid reimbursement rates; Medicaid's refusal to reimburse licensed clinical social workers when they bill under their own provider numbers rather than under a facility's, primary care providers for providing behavioral health services, and two providers for the same encounter; and an inadequate supply of behavioral health providers.

¹⁹³ See *supra* notes 87-91 & accompanying text.

¹⁹⁴ See N.J.A.C. § 8:43G-2.11(b).

¹⁹⁵ DHS's operational definition of "adjoining grounds" focuses on whether the rooflines of the facilities are connected in some fashion.

¹⁹⁶ See N.J.A.C. § 10:161B-1.1(b).

Different rules apply when hospital-based outpatient programs are not located on the hospital's campus.¹⁹⁷ As we have noted, a hospital is required to offer outpatient services for services offered on an in-patient basis.¹⁹⁸ If a hospital that provides a particular in-patient service does not have an outpatient clinic on its campus that offers that service, DOH policy is to consider one off-campus clinic that provides that service as being under the hospital's license.¹⁹⁹ An off-site program will require a separate ACF license from DOH to operate as a hospital-based off-site ambulatory care service facility.²⁰⁰

As a result, if a hospital with psychiatric services on its license but without an on-site outpatient psychiatric clinic seeks to have more than one off-site outpatient program offering psychiatric services, for example, DOH informed us that it will only deem one off-site program offering outpatient psychiatric services to be under the hospital's license. Any others would need to seek licensure from DHS. If the hospital has an on-site psychiatric clinic, DOH will not license any off-site outpatient psychiatric services under the hospital's license or as an ACF, and the facility will need to seek a MHP license from DHS.

DHS representatives informed us that historically DHS did not license hospital-based off-site programs. But in or about 2007 or 2008, when a hospital moved its outpatient mental health services six miles from the hospital and DOH took the position that this off-site program was not included in the hospital's DOH-issued license, DHS began its current practice of licensing hospital-based off-site outpatient MHPs.

As noted above, a DHS regulation requires hospital-based outpatient substance abuse treatment services offered in a designated off-site outpatient unit or facility to have a separate SA license from DHS in addition to the hospital's license from DOH.²⁰¹

It is unclear under New Jersey law whether hospital-based outpatient clinics may offer integrated primary physical and behavioral health services. Although DOH representatives did not take a formal position, they acknowledged that, with respect to on-site clinics or off-site clinics seeking to offer physical and behavioral health services that the hospital offers inpatient but not through an on-campus clinic, the facility already is licensed to provide both physical and

¹⁹⁷ See *id.* § 8:43G-2.11.

¹⁹⁸ See *id.* § 8:43G-5.21(a); see also *id.* § 8:43G-2.12(a)(19).

¹⁹⁹ As a hospital-based outpatient clinic, an off-site program must be financially and operationally integrated with and subordinate to the hospital, see *id.* § 8:43G-2.11(c), and is required to follow the hospital's rules regarding charity and free care programs, among others.

²⁰⁰ See *id.* § 8:43G-2.11(c).

²⁰¹ See *id.* § 10:161B-1.1(b). Some providers reported that they would not be able to obtain a license to offer off-site hospital-based behavioral health services because of a moratorium imposed by the State ten years ago. As discussed below, the moratorium concerns certification of new or relocated hospital-based off-site clinic services as Medicaid providers. See *Moratorium on New or Relocated Hospital-Based Off-Site Clinic Services Applications*, Agency Control No. 05-PN-007, 37 N.J.R. 3860(a) (Oct. 3, 2005). Thus it does not prohibit licensure of these programs, although it prevents Medicaid fee-for-service reimbursement of these services, which is a distinct though significant barrier to integration.

behavioral health services. In these circumstances, if the same licensee (that is, hospital staff) provides the services such that there are no accountability concerns, there is a strong argument that integration should be permitted. If the facility needs to change the physical space to facilitate the integration, it would need to check with DOH to confirm the changes comply with DOH's physical plant requirements. But if the facility is using existing space, DOH suggested that it would consider favorably a request to offer integrated services. If the hospital offers an on-site outpatient clinic for a particular behavioral health service, however, an off-site clinic seeking to offer the same service would need to seek licensure from DHS.

Representatives from DHS indicated that DHS generally defers to DOH on questions of regulating hospital-based outpatient services. But it did not take a firm policy position, citing the nuances of individual cases. It would be helpful for DOH and DHS to issue guidance or regulations clarifying these integration questions.

If a hospital license does not include inpatient behavioral health services, however, then it appears that a hospital-based behavioral health outpatient program on or off of the hospital's campus may not be included on the hospital's DOH license. The hospital would need to apply to DOH to add inpatient behavioral health services to its existing hospital license for it then to be permitted to offer behavioral health services through its outpatient program.²⁰² Adding to the hospital's inpatient behavioral health scope of services may require the hospital to go through the certificate of need process.²⁰³ Hospitals that do not provide inpatient behavioral health services, however, may apply for a license from DHS to provide outpatient behavioral health services.

9. Requirements to keep aspects of programs separate

We heard from a variety of facilities that the different licensure requirements from DOH and DHS would force facilities to maintain separate and in some cases duplicative physical plant and programmatic features, which served as barriers to integration.

We did not identify statutory or regulatory sources for many of these requirements. We asked DOH and DHS if they require separate facilities as a matter of policy. Specifically, we itemized a number of requirements that facilities had identified as barriers and asked each agency whether it would require a facility to satisfy them to obtain a license to provide primary physical and behavioral health services in an ambulatory setting.

As discussed in more detail in the Subparts that follow, there was, before DOH issued the Shared Space Waiver, considerable confusion in the regulated communities about what separation requirements exist. DOH generally insisted on separation of behavioral and physical

²⁰² See N.J.A.C. § 8:43G-2.2(c).

²⁰³ See N.J.S.A. § 26:2H-9 *et seq.*; N.J.A.C. § 8:33-1.1 *et seq.* Partial hospitalization, hospital-based medical detoxification for drugs and alcohol, and residential substance abuse treatment services, for example, are exempt from certificate of need requirements. See N.J.A.C. § 8:33-6.1(a)(4), (14), (31).

health clinical space, whereas DHS's concerns were and are less about physical plant requirements and more about programmatic features like staffing criteria and training. Several of these requirements were described by both agencies as subject to waiver in appropriate cases. The Shared Space Waiver relaxes some of the "keep separate" provisions that have bedeviled providers, and clarifies to an extent DOH's position with respect to space issues in ACFs. No such clarification has been issued with respect to MHPs and outpatient substance use disorder treatment facilities. Integration of physical and behavioral health services should occur in those settings also, particularly for people with serious mental illness.

Further discussions as to the reduction in the need for duplicative separate facilities will need to occur with the agencies as integration efforts go forward. It would be beneficial for the agencies to further clarify what requirements continue to exist and what criteria each considers when evaluating waiver requests, and to establish transparent processes for the consistent and expeditious consideration of waivers. As is described in Part III(B)(9)(d) below, the "keep separate" provisions may create the appearance or the reality of discriminatory treatment of people on the basis of their medical or disability status. With respect to requirements for separate entrances, waiting rooms, and bathroom facilities, for example, no statutory or regulatory basis for separate treatment has been cited, no public health purpose appears to be served, and stigmatizing differential treatment appears to result. As is described in Part V(B)(2) below, we recommend that the policy shift contained in the Shared Space Waiver be amplified and applied to other settings in which integrated services are clinically appropriate.

***a.* Physical plant requirements**

We consistently heard from a wide variety of facilities that DOH imposes physical plant requirements that stand as significant barriers to integration. DOH has a number of requirements based on physical plant concerns.²⁰⁴ We discussed these matters with DOH representatives, and

²⁰⁴ See, e.g., N.J.A.C. §§ 8:43A-2.4, 2.5 19.1-19.8.

they carefully explained those requirements that it disavowed,²⁰⁵ that it adhered to,²⁰⁶ and that it adhered to subject to waiver.²⁰⁷

Following our discussions with DOH, we received the Shared Space Waiver, which greatly clarified the physical plant requirements for ACFs. The key provisions of the Shared Space Waiver deserve extended explication:

- The DOH has waiver authority²⁰⁸ to permit the sharing of clinical space, and has granted such waivers “to a number of facilities” to promote behavioral health integration.
- Rather than proceed on an individual facility-by-facility basis, DOH instead, through the Shared Space Waiver, “grants a global waiver to permit the sharing of clinical space” to all DOH-licensed facilities providing primary care that wish to offer behavioral health services, subject to the conditions set out in the Waiver document.
- DOH intends this Waiver to relieve such licensed facilities from obtaining “additional space in order to have medical and behavioral services provided in separate clinical areas.”

²⁰⁵ For example, although some facilities reported that they were told by the State that they would have to provide separate break rooms and bathrooms for primary physical health providers/staff and behavioral health providers/staff, DOH denied that either is a requirement for licensure.

²⁰⁶ Until recently, *see infra* notes 208-216 & accompanying text, DOH generally has required ACFs to maintain separate clinical workspaces and has not permitted the sharing of clinical space between primary physical and behavioral health patients. As a result of this policy, DOH has required facilities to provide separate examination rooms, hallways, bathrooms (assuming the bathrooms are in the clinical space), medication storage, medication dispensing stations, and locked soiled utility rooms for primary physical and behavioral health patients. DOH noted that it was possible that it would grant a waiver of the separate bathroom for patients, separate medication storage and dispensing requirements, and separate utility room requirements in given situations, although it did not indicate that it routinely grants such waivers, unlike its response to questions about other physical plant requirements discussed above, *see supra* note 205. The Shared Space Waiver, discussed below, *see infra* notes 208-216 & accompanying text, seeks to establish a process through which physical and behavioral health providers may share clinical space, subject to certain conditions.

We note that DOH’s regulations require ACFs to store Schedule II drugs “in a separate, locked, permanently affixed compartment within the locked medication cabinet, medication room, refrigerator, or mobile medication cart;” they do not require that these drugs be locked in a separate room from non-Schedule II drugs. *See* N.J.A.C. § 8:43A-9.5(d).

²⁰⁷ DOH informed us that it routinely grants waivers of requirements for facilities to provide separate entrances and exits, waiting rooms, reception areas, and public bathrooms (that are not located within the clinical space) for primary physical and behavioral health patients. The agency explained that although its statutes and regulations do not expressly establish these requirements, it long has interpreted its rules to require licensure of a separate facility. For example, DOH interprets references in the ACF regulations to “a facility” to require licensure of a separate, distinct facility that may not share space. *See, e.g.,* N.J.A.C. § 8:43A-1.3 (defining an ambulatory care facility as “a health care facility or a distinct part of a health care facility”) (emphasis added); American Institute of Architects, *Guidelines for Design and Construction of Health Care Facilities*, 2010 edition, Part 3 Ambulatory Care Facilities, § 3.1 (incorporated by reference in N.J.A.C. §§ 8:43A-1.3, 19.1(a) and describing outpatient facilities as “an outpatient unit in a hospital, a freestanding facility, or an outpatient facility in a multiuse building containing an ambulatory health care facility as defined in the NFPA 101: *Life Safety Code* occupancy chapters”), available at <http://fgiguilines.org/digitalcopy.php> (last accessed June 11, 2015).

²⁰⁸ *See* N.J.A.C. § 8:43A-2.9.

- The Waiver *does not* relieve the DOH-licensed facility from DHS licensure requirements for the provision of behavioral health services; thus, the Shared Space Waiver is not a path to a single license for integrated behavioral care.
- The Shared Space Waiver sets out requirements for a DOH-licensed facility to apply for DHS licensure²⁰⁹ as a behavioral health provider:
 - The applicant, if an FQHC,²¹⁰ must submit a Change in Scope of Services application with its licensure application to DHS;
 - The applicant must attest in its application to DHS that:
 - the same legal entity will hold the DOH license and the DHS license(s); and
 - the entity is either not planning any physical plant modifications to provide the behavioral services, or, if it is, that it has received approval for such changes from DOH. If the entity is planning changes, it must provide a copy of the letter of DOH approval for the physical plant changes, or a letter from DOH that such changes do not require approval with its application for licensure to DHS.²¹¹
- The facility remains bound by DOH licensing requirements for ACFs.
- The facility must forward to DOH a copy of any DHS license(s).
- DOH and DHS “staff will work together to ensure” compliance with their respective licensing standards, and to respond to any questions or complaints about the operation of the facility.
- The facility must “understand and comply” with Medicaid requirements, including Change in Scope of Services requirements.²¹²

The Shared Space Waiver, then, abolishes one of the main impediments to behavioral health integration: the long-standing DOH interpretation of its regulations as requiring physical separation of the facilities providing behavioral and primary care services. The Shared Space Waiver thus allows FQHCs not presently providing behavioral health care to pursue behavioral health licensure from DHS without fear that their attempts to add behavioral health services will entail massive and costly building projects.

Although the Shared Space Waiver is a very positive step forward in New Jersey’s regulatory process, it leaves in place several impediments to integration.

²⁰⁹ It is not clear why DOH sets out in its Shared Space Waiver document terms and conditions for receipt of a license from a sister agency. One might infer that the agencies consulted; the Shared Space Waiver is issued, however, only by DOH.

²¹⁰ The Shared Space Waiver does not limit the requirement for the applicant to file a Change of Scope application to FQHCs, but the requirement seems to apply only in that context.

²¹¹ The rationale for this requirement is a bit unclear; if one of the purposes of the Shared Space Waiver is to streamline the licensure process, it is not clear how requiring a facility to obtain a letter from DOH that its facility changes do not require DOH approval furthers this purpose.

²¹² See Shared Space Waiver, *supra* note 9.

First, it does not address the terms under which primary care services can be added to MHPs or outpatient substance use disorder treatment facilities. It is to be hoped that some symmetrical understanding can be reached by the agencies to facilitate integration in those settings, in which people with the most serious behavioral health conditions receive their care.

Second, it was apparently beyond the scope of the Shared Space Waiver to address the financial barriers to integration, including the low Medicaid reimbursement rates,²¹³ and the Waiver assumes that DHS will require a Change in Scope of Services application.²¹⁴

Third, it does not allow for a facility to provide integrated services with a single license, although the simplification of the physical plant issues, and the acknowledgement of the capacity of staff from the agencies to collaborate in responding to inquiries and complaints provide hope that New Jersey is closer to being able to offer a unitary license for behavioral health care.

Very few physical plant requirements may arise under the Shared Space Waiver when the facility applies for DHS licensure. In our discussions, DHS expressed the view that separate medication dispensing stations in at least some SA programs are appropriate, given concerns about diversion of controlled substances.²¹⁵ The agency requires separate dispensing stations in opioid treatment programs, noting the high risk of diversion, particularly with methadone.²¹⁶ DHS acknowledged, however, that some medications, like Suboxone or Vivitrol, might be dispensed from a shared pharmacy window.

b. Programmatic requirements

While DOH's Shared Space Waiver resolved many physical plant issues, DHS is concerned with maintaining programmatic requirements that are specific to each licensing regime, such as staff credentials, training, and human resources policies.

For example, each license requires a clinical director and staff with qualifications particular to the specific license and corresponding scope of practice.²¹⁷ DHS acknowledged that

²¹³ See *infra* Part IV(F).

²¹⁴ See *infra* Part IV(B)(2).

²¹⁵ DHS represented that it is not common for MHPs to store medications.

²¹⁶ But see N.J.A.C. §§ 10:161B-11.1, 11.2, 14.1, 14.2, & 14.3 (setting forth detailed standards for operating opioid treatment programs, providing pharmaceutical services, administering drugs, and storing medications in SAs that notably do not mention maintaining separate medication dispensing stations for opioid treatment programs or Methadone).

²¹⁷ See, e.g., *id.* § 8:43A-1.4 (qualifications of ACF administrator); *id.* § 8:43A-1.10 (qualifications of director of nursing services in ACF); *id.* § 8:43A-1.11 (qualifications of drug counselors in ACF); *id.* § 8:43A-1.14 (qualifications of ACF medical director); *id.* §§ 8:43A-7.2 & 7.3 (responsibilities of ACF medical director); *id.* § 10:37E-2.6 (staffing requirements for MHPs, including duties of the program director); *id.* §§ 10:161B-1.4, 7.2 (qualifications and responsibilities of SA medical director); *id.* § 10:37D-2.13 (qualifications of clinical staff for MHPs); *id.* § 8:43A-26.4 (requiring ACF that provides drug abuse treatment to designate director of nursing services); §§ 10:161B-1.4 and 10:161B-7.2 (medical director requirements for outpatient substance abuse treatment facilities that offer opioid treatment and detoxification services); *id.* §§ 10:161B-1.5, 10:161B-8.1(a)(2), and 10:161B-8.2 (qualifications and

it was possible that an individual could satisfy the qualifications of each license, such that there was no categorical bar to one person satisfying the qualifications for more than one license. But the agency cautioned that this individual would need to meet the needs of the program and not just the qualifications on paper. Whether an individual can wear two hats will depend on the numbers of individuals the program will be serving and the composition of the rest of the staff, to ensure coverage in emergencies and compliance with required staffing ratios.²¹⁸ So while there is no categorical bar to shared staffing, facilities may well need to satisfy each separate staffing requirement to meet the needs of their patients.²¹⁹

Relatedly, DHS generally will insist that facilities maintain separate human resources policies, procedures, and trainings for each license. For example, MHPs and SAs have different training requirements to reflect the different skills needed and policies applicable in each setting.²²⁰ Some programs require fingerprinting and background checks.²²¹ DHS would want to preserve these specific programmatic features of the different licensing systems if facilities integrate.

Given the fact-sensitive nature of these issues, DHS does not routinely waive any of these requirements. But it will consider waiver requests on a case-by-case basis.

c. Medical records

Some facilities expressed their concern that they needed to be able to have two separate, locked rooms, one for behavioral health records, and the other for physical health records. They expressed frustration not only because this posed a physical space challenge for some facilities, but also because they want to maintain integrated health records to facilitate holistic care of their patients.

responsibilities of director of nursing services for SAs that provide opioid treatment programs and facilities providing detoxification services); *id.* §§ 10:161B-1.8, 10:161B-10.2 (SA requirement for director of substance abuse counseling services); *id.* § 10:161B-11.2 (required clinical staffing for SA offering opioid treatment services); *id.* § 10:161B-12.2 (required clinical staffing for SA offering detoxification services).

²¹⁸ See, e.g., *id.* § 10:161B-11.17 (requiring emergency phone coverage “by a designated staff member or by other arrangements or agreement 24 hours per day, seven days a week, to respond to clients in crisis, verify client dose levels, etc.” in SA’s opioid treatment program); *id.* § 10:161B-10.1(b) (establishing average ratio of substance abuse counselors to clients).

²¹⁹ DOH denied that facilities would be required to have a separate clinical director for each license regardless of the clinical qualifications of the director(s), “provided the clinical director meets all of DOH’s requirements for a medical director” set forth in *id.* § 8:43A-7.2.

²²⁰ See, e.g., *id.* § 8:43A-3.5 (requiring ACF to develop staff orientation plan and education plan regarding the facility’s specific policies, including infection control and emergency plans).

²²¹ See, e.g., *id.* § 10:161B-3.5(a)(2) (requiring for SAs “State-level criminal history record background checks supported by fingerprints no later than the time of hiring all staff, student interns and volunteers”).

Given federal and State privacy laws,²²² DHS indicated that some behavioral health records must be kept separate from the rest of a patient's medical records. For example, HIPAA requires that psychotherapy notes taken by a mental health professional during the course of treatment are kept separate from the patient's medical and billing records.²²³ Federal law also provides additional confidentiality protections to certain alcohol and substance use disorder prevention and treatment records.²²⁴

To the extent a facility uses paper records, it would need to keep these behavioral health records physically separate, although, as DHS agrees, the law does not require separate physical rooms. Rather a facility likely could satisfy the Department, for example, by keeping these records in a separate locked cabinet in the same room as the remainder of the medical records, in a cabinet to which only authorized behavioral health providers have the key.

Whether a facility may use an integrated electronic health record (EHR) will depend on the technology that it uses. If the facility can demonstrate to DHS that the EHR effectively restricts access to sections of the record that trigger heightened privacy protections and grants access to those records only to authorized users, for example, the facility likely will be able to use the system. It would be useful for DHS to publicize the EHR systems that satisfy its requirements or at least the criteria it will apply in determining whether to approve a facility's system.

d. Disability equity concerns

We reviewed New Jersey's licensure requirements, particularly the physical plant requirements, for possible disability discrimination implications. Prior to the distribution of the Shared Space Waiver, the requirements to keep aspects of programs and services separate raised concerns. The Americans with Disabilities Act (ADA) was enacted to combat the historic tendency to "isolate and segregate individuals with disabilities."²²⁵ Title II of the ADA protects people with

²²² The Center for Health & Pharmaceutical Law & Policy currently is researching and will be publishing a separate report in spring 2016 that evaluates the implications of federal and New Jersey privacy law on behavioral health integration in New Jersey.

²²³ See 45 C.F.R. § 164.501.

²²⁴ See 42 U.S.C. § 290dd-2; 42 C.F.R. Part 2. Although laws governing the confidentiality of health records are beyond the scope of this Report, it is worth noting that in February 2016, SAMHSA issued a proposed rule that is intended to "update and modernize" the Part 2 regulations governing substance use disorder prevention and treatment providers because "SAMHSA wants to ensure that patients with substance use disorders have the ability to participate in, and benefit from new integrated health care models without fear of putting themselves at risk of adverse consequences." DEPT OF HEALTH & HUMAN SERVC., SUBSTANCE ABUSE & MENTAL HEALTH SERVC. ADMIN., 42 CFR Part 2: Confidentiality of Alcohol and Substance Use Disorder Patient Records; Proposed Rule, 81 Fed. Reg. 6,988, 6,988 (Feb. 9, 2016), available at <https://www.gpo.gov/fdsys/pkg/FR-2016-02-09/pdf/2016-01841.pdf>.

²²⁵ 42 U.S.C. § 12101(2). See *id.* § 12101(5) ("individuals with disabilities continually encounter various forms of discrimination, including . . . overprotective rules and policies, failures to make modifications to existing policies and practices, . . . [and] segregation.").

mental disabilities, and people who are “perceived” to have a mental disability.²²⁶ Title II of the ADA prohibits discriminatory denial of the benefits of services and programs of public entities,²²⁷ including any department or agency of a state government.²²⁸ The nondiscrimination obligations of state agencies run to the administration of licensing programs:

A public entity may not administer a licensing or certification program in a manner that subjects qualified individuals with disabilities to discrimination on the basis of disability, nor may a public entity establish requirements for the programs or activities of licensees or certified entities that subject qualified individuals with disabilities to discrimination on the basis of disability.²²⁹

A public entity must comply with the ADA’s “integration mandate,”²³⁰ which requires that public services be made available “in the most integrated setting appropriate to the needs of qualified individuals with disabilities.”²³¹ To comply with the “integration mandate,” public entities must “make reasonable modifications in policies, practices, or procedures” to ensure inclusive treatment of people with disabilities.²³²

Further, a public entity is required to apply the inclusivity requirement of Title II not just to the public entity’s own activities. It must further ensure that its licensure requirements do not have the effect of requiring businesses it regulates to engage in segregating activity. The Department of Justice explains a public entity’s obligations as including that:

[A] public entity may not establish requirements for the programs or activities of licensees that would result in discrimination against qualified individuals with disabilities. For example, a public entity’s safety standards may not require the licensee to discriminate against qualified individuals with disabilities in its employment practices.²³³

²²⁶ *Id.* § 12102(1)(A) (people with “a physical or mental impairment that substantially limits one or more major life activities” protected under the ADA); *id.* § 12102(1)(C) and (3)(A) (people “subjected to an action prohibited under this chapter because of an actual or perceived physical or mental impairment” protected under ADA).

²²⁷ *Id.* § 12132.

²²⁸ *Id.* § 12131(1)(B).

²²⁹ 28 C.F.R. § 35.130(b)(6).

²³⁰ The United States Department of Justice adopts the popular recognition of 42 C.F.R. § 35.130(d) as reflecting the “integration mandate.” See Statement of the Department of Justice on Enforcement of the Integration Mandate of Title II of the Americans with Disabilities Act and *Olmstead v. L.C.*, at 2 n. 5 (2011), available at http://www.ada.gov/olmstead/q&a_olmstead.pdf.

²³¹ 42 C.F.R. § 35.130(d).

²³² *Id.* § 35.130(b)(7). Modifications need not be made if the public entity can “demonstrate that making the modifications would fundamentally alter the nature of the service, program, or activity.” *Id.*

²³³ U.S. Dep’t of Justice, Title II Technical Assistance Manual (TAM) § II-3.7200, available at <http://www.ada.gov/taman2.html>; see also *Reeves v. Queen City Transportation, Inc.*, 10 F. Supp. 2d 1181, 1185-87

The physical plant requirements in place prior to the issuance of the Shared Space Waiver appeared to subject to differential treatment both people with mental disabilities and those perceived to have mental disabilities. A requirement that a facility offering both physical and behavioral health services maintain separate examination rooms or bathrooms in clinical areas, for example, clearly and visibly treated people differently on the basis of their need for behavioral health services. Without the interposition of an affirmative defense,²³⁴ such separate treatment seemed to violate the regulatory requirements for nondiscriminatory treatment.

We applaud DOH for fostering appropriate integration by issuing the Shared Space Waiver. It is clear that DOH reconsidered the continuing need for such “keep separate” requirements, and made the judgment that such separation is no longer categorically appropriate. The Shared Space Waiver is an important move in the direction of integration, and reflects the State’s recognition that shifts in clinical best practices must be mirrored in New Jersey’s licensure requirements.

IV. Financing- and Reimbursement-Related Barriers to Integrated Care in New Jersey

A. The Link between Facility Licensure and Reimbursement for Behavioral Health Procedure Codes

One potential barrier to providing behavioral health care services to New Jersey Medicaid beneficiaries in a primary care setting is the requirement that clinics have a mental health license from DMHAS before being reimbursed by DHS’s Division of Medical Assistance and Health Services (DMAHS) for providing mental health services. The Department of Human Services’ regulations provide that each independent clinic, including each satellite office, must “be individually approved by the New Jersey Medicaid and NJ FamilyCare fee-for-service programs

(D. Colo. 1998) (distinguishing for Title II purposes between discriminatory acts of a regulated business that are, and are not, mandated by a public entity).

²³⁴ It may be that public health and safety motivates the policy. Such concerns, however, only form a defense to differential treatment on the basis of actual or perceived disability if the differential policies “are based on actual risks, not on mere speculation, stereotypes, or generalizations about individuals with disabilities.” 42 C.F.R. § 35.130(h). In the alternative, it may be that the policy is motivated by a concern that people with behavioral conditions present a threat of harm to others using the facility. A defense based on such a threat is only valid, however, if the public entity makes:

[A]n individualized assessment, based on reasonable judgment that relies on current medical knowledge or on the best available objective evidence, to ascertain: the nature, duration, and severity of the risk; the probability that the potential injury will actually occur; and whether reasonable modifications of policies, practices, or procedures or the provision of auxiliary aids or services will mitigate the risk.

Id. § 35.139.

and enrolled with the Division's fiscal agent, for approved service(s)."²³⁵ The term "independent clinic" encompasses, among other entities, ACFs, FQHCs, and mental health clinics.²³⁶

In order to be approved as a Medicaid provider, an independent clinic must have "a certificate of need and/or license, if required, from [DOH] or [DMHAS], or from both agencies" ²³⁷ FQHCs must be (1) approved by the Centers for Medicare & Medicaid Services (CMS) and (2) licensed as ACFs, while mental health clinics must have secured "approval" by DMHAS.²³⁸ The regulations specifically state that a clinic can only provide the services "it is licensed or authorized to provide by [DOH] or [DMHAS], or both, if applicable . . ." ²³⁹ DMAHS, then, requires as a condition of enrollment that independent clinics secure and abide by the terms of any approval or license required by CMS, DOH, or DMHAS.

The question, then, is whether an "independent clinic" that is licensed as an ACF, including FQHCs, can be reimbursed by Medicaid for providing psychotherapy or other mental health treatment, or whether it must also be licensed as a mental health clinic to secure reimbursement. In theory, it should be clear to each clinic what codes they can claim reimbursement for, because the regulations state that they are limited to the Healthcare Common Procedure Coding System (HCPCS) "procedure codes that correspond to the allowable services included in the clinic's provider enrollment approval letter" ²⁴⁰ Not all of these letters are sufficiently specific to provide the necessary guidance, though.

²³⁵ N.J.A.C. § 10:66-1.3(a).

²³⁶ *Id.* §§ 10:66-1.1(a) ("The term independent clinic includes, but is not limited to, clinic types such as: ambulatory care facility, ambulatory surgical center, ambulatory care/family planning clinic, and Federally qualified health center.") & 10:66-1.3(c)(5) ("[E]ach independent clinic shall obtain approval from the relevant Federal and State agency(ies), as required by law, rule and/or regulation, including, but not limited to, the following: . . . For a mental health clinic, approval by the Division of Mental Health [and Addiction] Services of the New Jersey Department of Human Services or by a comparable agency of the state in which the facility is located[.]"

²³⁷ *Id.* § 10:66-1.3(b).

²³⁸ *Id.* § 10:66-1.3(c)(1) and (5).

²³⁹ *Id.* § 10:66-1.3(b)(1). The regulations define a mental health clinic as "an independent clinic, whether freestanding, or a distinct component of a multi-service ambulatory care facility, which meets the minimum standards established by the Community Mental Health Services Act implementing rules, including, but not limited to, N.J.A.C. 10:37, and is approved by the Division of Mental Health [and Addiction] Services, in accordance with that Division's rules . . ." *Id.* § 10:66-1.2.

²⁴⁰ *Id.* § 10:66-1.5(b). See generally CA. MENTAL HEALTH SERVS. AUTH'Y, *How Does Integrated Behavioral Healthcare Work? Billing, Reimbursement and Financing*, <http://www.ibhp.org/?section=pages&cid=141> (last visited Sept. 30, 2015) ("The Healthcare Common Procedure Coding System (HCPCS), established in 1978, is a standardized system to describe specific items and services provided in health care delivery. It was developed to ensure that claims for Medicare, Medicaid, and other health insurance programs are processed consistently. Initially, use of the codes was voluntary, but with the advent of HIPAA in 1996 (Health Insurance Portability and Accountability Act of 1996), the codes became mandatory. A subsystem of the HCPCS is the CPT-4 (Current Procedural Terminology), a numeric coding system maintained by the American Medical Association to identify medical services and procedures furnished by physicians and other health care professionals. For listings and explanations of all codes, go to the Centers for Medicare and Medicaid Services.").

Subchapter 6 of Section 10:66 of the New Jersey Administrative Code includes schedules of the HCPCS codes recognized by New Jersey Medicaid along with the maximum fee allowed for each. Subchapter 6 instructs independent clinics to add the modifier “UC” to “identify certain mental health services provided by independent clinic providers”; the modifier “HE” is added to identify services provided by a MHP.²⁴¹ The schedules do not indicate which types of providers can bill using which codes, however.

An Appendix to Section 10:66 incorporates the provider-specific Fiscal Agent Billing Supplements, which can be found at www.njmmis.com, a website maintained by Molina Medicaid Solutions.²⁴² Among other things, Molina processes and pays claims for services, including behavioral health care services, that are not the responsibility of the Medicaid managed care organizations.²⁴³ Neither the Fiscal Agent Billing Supplements nor the Procedure Code Listings or other Molina resources available at www.njmmis.com indicate which providers are authorized to bill which codes.

Additional sources of information available to providers are DMAHS newsletters and Medicaid alerts. As Molina explains, DMAHS uses newsletters “[t]o notify providers of changes and to help them understand the Medicaid policy and procedures[,]” while Medicaid Alerts are “[u]sed to fast track important policy and procedural changes to the providers.”²⁴⁴ In a July 2013 Newsletter broadly addressed to “Physicians, Psychologists, Independent Clinics, Federally Qualified Health Centers, [and] Residential Treatment Centers[,]” DMAHS set forth new behavioral health procedure codes covering psychiatric evaluation and psychotherapy, and their corresponding reimbursement amounts.²⁴⁵ In October 2013, DMAHS sent a follow-up newsletter, captioned “Clarification of Billing Procedures for Certain Mental Health and Substance Abuse Services,” in which it indicated that just “[t]hree (3) types of providers are eligible to bill some or all of these mental health services, as well as methadone and narcotic clinic visit procedure codes: Independent Clinics specializing in mental health; Work First New Jersey (WFNJ) Substance Abuse Initiative (SAI) providers; and Non-SAI substance abuse providers.”²⁴⁶

²⁴¹ N.J.A.C. § 10:66-6.1(b).

²⁴² *Id.* § 10:66, Appx.

²⁴³ Molina Medicaid Solutions, Independent Clinic Services Fiscal Agent Billing Supplement 1-1 (July 2015), available at https://www.njmmis.com/downloadDocuments/BillingSup_IndepClinic.pdf; Roxanne Kennedy, Presentation, *NJ Family Care Expansion and Provider Enrollment FAQs* (Jan. 17, 2014), available at <https://njsams.rutgers.edu/njsams/Documents/DMHASContactForFFSProviders/Family%20Care%20Expansion%20and%20Medicaid%20Provider%20Enrollment.pdf>.

²⁴⁴ Molina Medical Solutions, Federally Qualified Health Center (FQHC) Training 5 (July 2015).

²⁴⁵ State of New Jersey Department of Human Services, Division of Medical Assistance & Health Services, UPDATE-2013 Changes in Billing Procedure Codes for Certain Behavioral Health Services, Vol. 23, No. 11, 2013, at 1, available at <https://www.njmmis.com/downloadDocuments/23-11.pdf>.

²⁴⁶ State of New Jersey Department of Human Services, Division of Medical Assistance & Health Services, Clarification of Billing Procedures for Certain Mental Health and Substance Abuse Services, Vol. 23, No. 18, at 1, available at <https://www.njmmis.com/downloadDocuments/23-18.pdf>.

In correspondence with the authors, a DMAHS official confirmed that the agency interprets the regulations to require that ACFs, including FQHCs, be dually-licensed as mental health clinics before they can be reimbursed by Medicaid for mental health services they provide. While mental health clinics can provide up to eight hours a week of primary care before the requirement that they be dual-licensed as an ACF is triggered, there is no analogous allowance for ACFs that wish to provide a limited number of hours of behavioral health care.

We also heard that hospital-based outpatient clinics were having an especially difficult time securing the licensure to add behavioral health services to their scope of services. Reportedly, some hospitals were told that their outpatient clinics were not eligible to apply for a MHP license because of a long-standing outpatient clinic moratorium. Effective July 1, 2005, New Jersey Medicaid imposed a moratorium on *new or relocated* hospital-based *off-site* clinic services.²⁴⁷ Reportedly, the State was concerned with the proliferation of clinics, including substance abuse treatment facilities. During the moratorium, Medicaid will not accept, review, or approve applications for these programs.²⁴⁸ This means that these programs may not bill Medicaid for these services. This moratorium applies to providers seeking reimbursement through the Medicaid fee-for-service program. It does *not* apply to Medicaid managed care organizations, which are free to contract with any licensed provider, nor, apparently, does the moratorium affect the ability of the DMHAS to *license* such facilities. Medicaid may grant “exceptions” to this moratorium “on a case-by-case basis” if it deems services “necessary . . . to meet special beneficiary needs.”²⁴⁹ Representatives of New Jersey Medicaid informed us that the agency has granted requests for exceptions each year. Medicaid is required to analyze the certification methodology for hospital-based, off-site clinic services during the moratorium, although we have not been able to locate any information about this analysis.

B. FQHCs and Reimbursement for Behavioral Health Procedure Codes

1. Behavioral health procedure codes recognized by NJ Medicaid

Because FQHCs are a creation of and at least in part governed by federal law, the rules regarding how they will be compensated for the services they provide sometimes diverge from the rules governing other ACFs. The federal Medicaid statute requires that each state ensure that individuals enrolled in the program have access to FQHC services.²⁵⁰ The statute defines FQHC

²⁴⁷ See *Moratorium*, *supra* note 201.

²⁴⁸ See *id.*

²⁴⁹ *Id.*

²⁵⁰ 42 U.S.C. § 1396a(a)(10)(A) (“A State plan for medical assistance must—(10) provide—(A) for making medical assistance available, including at least the care and services listed in paragraphs (1) through (5), (17), (21) and (28) of section [1396d(a)] & 42 U.S.C. § 1396d(a)(2) (defining “medical assistance” to include “[f]ederally-qualified health center services (as defined in subsection (l)(2)) and any other ambulatory services offered by a Federally-qualified health center and which are otherwise included in the plan...”). See *also id.* § 1396u-7(b)(4) (providing that “a State may not provide for medical assistance through enrollment of an individual with benchmark coverage or benchmark equivalent coverage under this section unless--(A) the individual has access [to FQHC services].”).

services to include (1) ambulatory services that an FQHC offers and that are included in the state's Medicaid plan,²⁵¹ and (2) the services described in the section of the Medicare statute defining "rural health clinic services[.]" which includes, among other things, services provided by a "clinical psychologist" or "clinical social worker."²⁵²

In September of 2003, the Director of the Center for Medicaid & State Operations at CMS sent a memorandum to the Administrator at the Health Resources and Services Administration (HRSA) in response to concerns that FQHCs were "experiencing difficulty obtaining Medicaid payments for their behavioral health services furnished by clinical psychologists, clinical social workers, and nurse practitioners[.]"²⁵³ In the memorandum, CMS clarified that FQHCs that have satisfied state Medicaid requirements are entitled to be paid for "behavioral health services furnished by clinical psychologists, clinical social workers, and nurse practitioners."²⁵⁴

For a number of years, FQHCs in New Jersey that are licensed as ACFs but not as mental health clinics have used a limited set of behavioral health HCPCS codes provided by Medicaid to be reimbursed for certain mental health and substance use disorder treatment services. The codes and the types of providers authorized to use them are set forth in a spreadsheet that DMAHS first distributed to New Jersey FQHCs in 2004. The permitted codes cover services one would expect could be provided in an outpatient primary care setting, including intake evaluation, psychological testing, psychotherapy, and evaluation and management. For each code, the spreadsheet indicates whether it can be provided by a psychiatrist, psychologist, "Advanced Practice Nurse-MH", or licensed clinical social worker (LCSW).

Some New Jersey FQHCs told us that they have encountered rejections when attempting to bill for services that the DMAHS spreadsheet indicates are covered. Coverage of services provided by a psychiatrist was a particular concern. That behavioral health services provided by primary care physicians and other primary care providers are not included on the spreadsheet could also hinder efforts to provide integrated care. In correspondence with the authors, a DMAHS official stated definitively that FQHCs will not be reimbursed by Medicaid for behavioral health services provided by primary care physicians, although subsequent conversations with DMAHS officials were less definitive on this point.

The State's decision not to cover behavioral health services provided by primary care providers at FQHCs creates a barrier to integrated care; if this is not in fact DMAHS' position,

²⁵¹ *Id.* § 1396d(a)(2).

²⁵² *Id.* § 1396d(l)(2)(A) & 42 U.S.C. § 1395x(aa)(1).

²⁵³ Memorandum from The Director, Center for Medicaid & State Operations, to The Administrator, Health Resources and Services Administration (Sept. 22, 2003), available at <http://bphc.hrsa.gov/policiesregulations/policies/pdfs/pin200405.pdf>.

²⁵⁴ U.S. DEP'T OF HEALTH & HUMAN SERVCs., HEALTH RESOURCES & SERVCs. ADMIN., BUREAU OF PRIMARY HEALTH CARE, Program Information Notice 2004-05, *Medicaid Reimbursement for Behavioral Health Services* (Oct. 31, 2003), available at <http://bphc.hrsa.gov/policiesregulations/policies/pdfs/pin200405.pdf>.

clarification would be very helpful in facilitating access to care. In addition, we frequently heard that FQHCs' primary care providers in many low-income communities are the only source of access to medication-assisted treatment for individuals with opiate addiction. In a November 2014 newsletter, however, DMAHS indicated that it will in fact reimburse FQHCs for buprenorphine treatment provided by primary care physicians.²⁵⁵ According to the newsletter, FQHCs are to bill for these appointments "as a medical service (medication visit),"²⁵⁶ and therefore they are part of New Jersey's Medicaid managed care and not the behavioral health carve-out. Officials emphasized to us that Medicaid-approved primary care providers both in private practice and at FQHCs who have the requisite waiver from the U.S. Drug Enforcement Administration may use an Evaluation and Management (E/M) code for medication assisted treatment for opiate addiction if in fact they provide the services required by these codes, including performing a physical examination. DMAHS notes, though, that physicians should refer patients taking buprenorphine to "psychosocial counseling services[.]"²⁵⁷

FQHCs also reported that Medicaid's refusal to reimburse for group therapy has served as a barrier to integration. As Medicaid explained to us, the agency is not opposed in principal to reimbursing for group therapy. Rather its concern is with billing for group therapy under the current PPS system. Medicaid is concerned that PPS bills would be generated for each participant in a group therapy session, an outcome Medicaid regards as inappropriate. Officials from Medicaid indicated to us that they are amenable to devising a methodology to determine an appropriate reimbursement rate for group therapy appointments. Because this reimbursement amount would be an alternative payment methodology, however, the State and FQHCs must agree to it, and it would require CMS approval as part of the State Plan.²⁵⁸

2. Change in Scope of Services

FQHCs differ significantly from other providers in the way that they are compensated by Medicaid. Unlike other providers, whose reimbursement usually varies depending on the specific services provided, FQHCs are paid a pre-set amount per "encounter." There are five types of reimbursable encounters, including a "medical encounter," which "is a face-to-face contact between a beneficiary and a physician or other licensed practitioner acting within his or her respective scope of practice, including a podiatrist, optometrist, chiropractor, advanced practice

²⁵⁵ State of New Jersey Department of Human Services, Division of Medical Assistance & Health Services, Buprenorphine Guidelines, Vol. 24, No. 13, 2014, at 1, available at <https://www.njmms.com/downloadDocuments/24-13.pdf>.

²⁵⁶ *Id.*

²⁵⁷ *Id.*

²⁵⁸ See 42 U.S.C. § 1396a(bb)(6)(A). It also is possible to pilot an alternative payment methodology with a subset of assenting FQHCs. See, e.g., Amanda Waldroupe, State of Reform, "OR: Alternative Payment Methodologies Seen As Key to Incentivizing Quality Care" (Apr. 23, 2014) (reporting that three Oregon FQHCs are conducting pilot projects using alternative payment methodologies designed to incentivize patient-centered and coordinated care), available at <http://stateofreform.com/news/industry/healthcare-providers/2014/04/alternative-payment-methodology-seen-key-sustaining-medicaid/>.

nurse, or nurse midwife[,]” and a “psychiatric encounter,” which “is a face-to-face contact between a beneficiary and a licensed mental health professional in which a covered mental health clinic service is provided.”²⁵⁹

The rate New Jersey Medicaid pays FQHCs per encounter is determined using a “Prospective Payment System (PPS).” Each FQHC’s PPS rate was set for fiscal year 2001 at an amount equal to 100% of its average per encounter cost in fiscal years 1999 and 2000.²⁶⁰ Since 2001, FQHCs’ PPS rates have increased by an inflation factor.²⁶¹ The other basis by which a PPS rate may be adjusted is “to take into account any increase or decrease in the scope of such services furnished by the center or clinic during that fiscal year.”²⁶²

The question of what constitutes an increase or decrease in the scope of services such that an FQHC’s PPS rate would need to be adjusted can be an important factor in FQHCs’ determination of whether to add behavioral health services to facilitate integrated care. If the addition of such services comprises a change in scope of services for PPS purposes, an FQHC that adds behavioral health services would experience an adjustment in its PPS rate.

There are no federal regulations related to the statutory language governing a determination of whether adjustments in services constitute a change in the scope of services for Medicaid purposes. In a Frequently Asked Questions document sent to Medicaid administrators on September 12, 2001,²⁶³ however, CMS wrote:

Question: The legislation states that the PPS rate must be ‘adjusted to take into account any increase or decrease in the scope of such services furnished by the center or clinic during the fiscal year.’ What is meant by a ‘change in the scope of such services’?

Answer: A change in the scope of FQHC/[Rural Health Clinic (RHC)] services shall occur if: (1) the center/clinic has added or has dropped any service that meets the definition of FQHC/RHC services as provided in section 1905(a)(2)(B) and (C) [42 U.S.C. § 1396d(a)(2)(B) and (C)]²⁶⁴; and, (2) the service is included as a

²⁵⁹ N.J.A.C. § 10:66-4.1(a)(2) & (3).

²⁶⁰ 42 U.S.C. § 1396a(bb).

²⁶¹ *Id.* § 1396a(bb)(3)(A) (explaining that the “Medicare Economic Index” “means that factor that adjusts reimbursement rates for annual inflation”).

²⁶² *Id.* § 1396a(bb)(3)(B).

²⁶³ Memorandum from Acting Director, Family and Children’s Health Programs Group, to Associate Regional Administrators, Division of Medicaid and State Operations, Regions I-IV, VI-VIII, X, Associate Regional Administrator, Division of Medicaid and Children’s Health, Region V, Associate Regional Administrator, Division of Medicaid, Region IX (Sept. 12, 2001), available at [http://www.nachc.com/client/PPS%20Q%20%20A's%20\(2001\).pdf](http://www.nachc.com/client/PPS%20Q%20%20A's%20(2001).pdf).

²⁶⁴ The cited provisions refer to the following definition of “Federally-qualified health center services”:

covered Medicaid service under the Medicaid state plan approved by the Secretary. A change in the ‘scope of services’ is defined as a change in the type, intensity, duration and/or amount of services .

...

Question: How are adjustments (increases/decreases) to be recognized?

Answer: The state may require that the center/clinic be responsible for informing the state of a change (increases and decreases) in the scope of services in the fiscal year. Or, the state itself may want to assume the responsibility for identifying an increase or decrease in the scope of services. The state should describe the adjustment process in the state plan.²⁶⁵

Like the federal statute, then, CMS uses the mandatory word “shall” to characterize the change of scope process. That said, CMS clearly indicated that it is up to each state to decide whether it should allow FQHCs to be responsible for the initiation of the change of scope process, or to itself be responsible for identifying activity that triggers a change in scope.

New Jersey statutory law sheds no light on this issue. State regulations, however, provide that “[t]he PPS encounter payment rates *may* be adjusted for increases or decreases in the scope of services furnished by the FQHC during that fiscal year.”²⁶⁶ The regulation goes on to use mandatory language, however, stating that “[p]roviders shall notify the Division of Medical Assistance and Health Services (DMAHS) in writing at least 60 days prior to the effective date of any changes and explain the reasons for the change.”²⁶⁷ Later, the regulation again uses the

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- (A) physicians' services and such services and supplies as are covered under section 1861(s)(2)(A) [subsec. (s)(2)(A) of this section] if furnished as an incident to a physician's professional service and items and services described in section 1861(s)(10) [subsec. (s)(10) of this section],
 - (B) such services furnished by a physician assistant or a nurse practitioner (as defined in paragraph (5)), by a clinical psychologist (as defined by the Secretary) or by a clinical social worker (as defined in subsection (hh)(1)), and such services and supplies furnished as an incident to his service as would otherwise be covered if furnished by a physician or as an incident to a physician's service

42 U.S.C. § 1395x(aa)(1)(A)-(B).

²⁶⁵ *Id.*

²⁶⁶ N.J.A.C. § 10:66-1.5(d)(vi) (emphasis added). A change in scope of service is defined as follows: “(A) The addition of a new FQHC covered service that is not incorporated in the baseline PPS rate or a deletion of a FQHC covered service that is incorporated in the baseline PPS rate; (B) A change in scope of service due to amended regulatory requirements or rules; (C) A change in scope of service resulting from relocation, remodeling, opening a new clinic or closing an existing clinic site; and/or (D) A change in scope of service due to applicable technology and medical practice.” *Id.* § 10:66-1.5(d)(vi)(1).

²⁶⁷ *Id.* § 10:66-1.5(vi)(2)(A)

voluntary “may,” but this seems to relate to the timing of the submission and not to the submission itself.²⁶⁸ An Appendix to the regulations states that “[t]he Medicaid Change in Scope of Service Reporting Forms must be completed whenever a change in scope of service (as defined in the Medicaid regulations) occurs.”²⁶⁹

In 2009, DMAHS proposed amending the regulations to “change the word ‘may’ to ‘shall’ to clarify that providers are required to submit Change in Scope of Service Applications”²⁷⁰ For example, DMAHS proposed changing “[t]he PPS encounter payment rates *may* be adjusted for increases or decreases in the scope of services” to “[t]he PPS encounter payment rates *shall* be reviewed for increases or decreases in the scope of services”²⁷¹ In the end, though, DHS decided against amending the regulations. The agency explained that it would “not adopt the proposed amendments . . . changing the words ‘may’ to ‘shall,’ along with accompanying grammatical revisions” because it had “determined that no additional clarification is required because the existing regulations clearly require FQHCs to complete a Change in Scope of Service Application whenever a change in scope of service occurs.”²⁷²

Missing from both federal and State law, however, is guidance on precisely what constitutes a change of scope triggering an adjustment to PPS rates. In practice, DMAHS has not required FQHCs providing behavioral health services pursuant to the spreadsheet of allowable codes to submit a change in scope of services application. What is less certain under both federal and State law is the extent of the change in the “type, intensity, duration, or amount” of behavioral health services that triggers a change of scope for an FQHC.

Clearly it is required under both federal and State law that a change of scope give rise to a PPS reevaluation. It is also clear that it is appropriate that there be a well-understood and workable threshold of change that would trigger a requirement for a change of scope. CMS has explained that an adjustment to PPS rates occurs when there is a change in the “type, intensity, duration and/or amount of services.”²⁷³ The extent of change that triggers PPS adjustment is not defined; that triggering change, however, should involve something more than a minor or *de minimis* change of practice. For example, a minor increase or decrease from the base year in the

²⁶⁸ *Id.* § 10:66-1.5(vi)(3)(“Providers may submit Change in Scope of Service Applications either: (A) Once during a calendar year, by October 1, with an effective date of January 1 of the following year; or (B) When the change(s) in scope of service exceed(s) 2.5 percent of the allowable per encounter rate as determined for the fiscal period. The effective date shall be the implementation date of the change in scope of service that exceeds the 2.5 percent minimum threshold for a mid-year adjustment.”).

²⁶⁹ *Id.* § 10:66-4, Appx. D.

²⁷⁰ 41 N.J. Reg. 2561(a) (July 6, 2009).

²⁷¹ *Id.*

²⁷² 41 N.J. Reg. 4791(a) (Dec. 21, 2009).

²⁷³ Memorandum from Acting Director, *supra* note 263.

utilization of a particular service provided should not trigger a recalculation of the PPS rate.²⁷⁴ Some states set a percentage-based trigger for the extent of increases or decreases in intensity or amount of service for change of scope analysis.²⁷⁵ On the other hand, the addition of what is clearly a new type of service could be an appropriate trigger, as the nature of the treatment provided by the FQHC will have changed.²⁷⁶

Many of New Jersey's FQHCs seeking to integrate behavioral and physical health care have long provided, and been compensated for, some behavioral health services. It is appropriate for DMAHS to clearly set out when an addition to those services will be construed as a change of scope requiring recalculation of PPS rates. It may be that DMAHS could, by regulation, define a trigger for such recalculation when, first, behavioral health services were not included in the base year calculation of the FQHC's PPS rate, and, second, such services reach a numerical or percentage threshold calculated as a percentage of the FQHC's Medicaid billing. This combination of a new service and a threshold cost increase is used in other states,²⁷⁷ and has several virtues. It would be clear and relatively simple to calculate; would recognize that some level of behavioral health services have long been associated with FQHCs' provision of primary care; and would provide some breathing space for FQHCs to expand to accommodate the needs of their patients for treatment of mild to moderate behavioral health care. The creation of such a regulatory clarification would doubtless involve consultation with the regulated community, advocates, and other interested persons.

Prior to providing clarification of the triggering event for change of scope, DMAHS could provide specific information to FQHCs as to the nature of the effects of a triggering event. Specifically, the limited nature of that change in PPS appears not to be well known. Under current practices, DMAHS will reevaluate an FQHC's PPS rate if it is determined that the FQHC has experienced a change in scope of services. That adjustment, however, does not reevaluate the cost basis for services that were in the FQHC's original base. Instead, the reevaluation would only involve examination and tests of reasonableness of the new service's incremental costs and utilization.²⁷⁸ Some adjustment of the PPS rate is required by federal law when an appropriate trigger – which may be defined by the State – is tripped. Confusion or misinformation about the limited nature of the adjustment may be unduly inhibiting FQHCs' enhancement of behavioral health services.

²⁷⁴ See NATIONAL ASSOCIATION OF COMMUNITY HEALTH CENTERS, Issue Brief #6: Defining an Effective Change of Scope Process (Jan. 2012), available at <https://www.nachc.com/client/Medicaid%20Change%20in%20Scope%20FINAL%201.121.pdf>.

²⁷⁵ *Id.*

²⁷⁶ *Id.*

²⁷⁷ See, e.g., Wash. Ann.Code § 182-549-1500, available at <http://apps.leg.wa.gov/wac/default.aspx?cite=182-549-1500>; Indiana FQHC/RHC Change in the Scope of Service Guidelines (2009), available at <http://in.mslc.com/uploadedFiles/FQHC-RHC%20Change%20in%20Scope%20of%20Service%20Guidelines%20and%20Form.pdf>.

²⁷⁸ Telephone conversation with DMAHS officials, March 9, 2016.

C. Individual Provider Qualifications and Reimbursement for Behavioral Health Procedure Codes

Limits on the types of providers that can bill Medicaid for behavioral health services are another potential reimbursement-related barrier to integrated care. Many of the providers we interviewed expressed confusion regarding what the applicable limits are. One person stated that Medicaid would not reimburse a primary care physician for providing behavioral health services or for treating a patient with a behavioral health diagnosis, while another interviewee suggested that primary care physicians could be reimbursed for treating behavioral health issues, but only if they are medically-related, such as depression arising from cancer. Another person we interviewed told us that, with regard to outpatient therapy services, Medicaid will reimburse when licensed counselors provide therapy, but not when social workers do.

The regulations set forth a list of providers who are “eligible to apply to participate as Medicaid/NJ FamilyCare-Plan A providers[.]”²⁷⁹ Participating providers are entitled to bill Medicaid directly in their individual capacity. The list of eligible providers includes psychologists, advanced practice nurses, physicians, and physician groups. This, though, does not answer whether primary care physicians and advanced practice nurses will be reimbursed for providing behavioral health services.

The regulations governing reimbursement of mental health services contemplate the involvement of a physician. The regulations require that “[a]n intake evaluation shall be performed within 14 days of the first encounter or by the third clinic visit, whichever is later, for each beneficiary being considered for continued treatment.”²⁸⁰ That evaluation must include “a physician and an individual experienced in diagnosis and treatment of mental illness.”²⁸¹ It is possible for the same individual to fulfill both criteria, if he or she is qualified.²⁸² This regulatory language leaves it unclear whether the “physician” referenced can be a primary care physician.

A presentation prepared by a Medicaid official indicates that New Jersey Medicaid’s State Plan includes behavioral health services provided by psychiatrists, psychologists, or certified nurse practitioners.²⁸³ New Jersey’s 2011 proposal for a Section 1115 demonstration waiver, however, includes a table setting forth covered behavioral health services by covered population that is more inclusive.²⁸⁴ The table indicates that all of the Medicaid plans cover behavioral health

²⁷⁹ N.J.A.C. § 10:49-3.1(b)(1).

²⁸⁰ *Id.* § 10:66-2.7(j).

²⁸¹ *Id.* § 10:66-2.7(j)(5).

²⁸² *Id.*

²⁸³ Kennedy, *supra* note 243.

²⁸⁴ STATE OF NEW JERSEY DEPARTMENT OF HUMAN SERVICES, IN COOPERATION WITH THE DEPARTMENT OF HEALTH AND SENIOR SERVICES AND THE DEPARTMENT OF CHILDREN AND FAMILIES, SECTION 1115 DEMONSTRATION COMPREHENSIVE WAIVER 109-112 (SEPT. 9, 2011) (hereinafter “COMPREHENSIVE WAIVER”), available at

services provided by a “Physician / PCP Practitioner.”²⁸⁵ Elsewhere, the proposal explains that Medicaid managed care organizations will continue to be responsible for “primary care office visits to treat BH conditions[.]”²⁸⁶ Representatives from New Jersey Medicaid explained, however, that the 1115 waiver did not signal a change in the State’s policy regarding Medicaid reimbursement of behavioral health services. Rather, recognizing that a substantial proportion of behavioral health prescriptions are written by physical health providers, the State in its 1115 waiver was reassuring CMS that in moving to managed behavioral health care, it would not interfere with prescribers who are practicing within the scope of their licenses.

In correspondence with the authors, an official from DMAHS took the position that Medicaid would reimburse physicians for providing whatever services their licenses allow. While some behavioral health codes are limited by setting, most psychotherapy codes are open to a community-based primary care physician. For example, the official explained, certain physicians who provide both Evaluation and Management (E/M) services and 30 minutes of psychotherapy can bill using the psychotherapy add-on code 90833 in addition to the appropriate E/M code.²⁸⁷ Similarly, if an eligible physician provides E/M services and 45 minutes of psychotherapy, s/he would be able to bill code 90836 in conjunction with the appropriate E/M code. These codes, which CMS created in or about 2013, entitle the provider to enhanced reimbursement. Although these codes are not limited to use by psychiatrists, we have not identified a list of which physicians are permitted to bill using them. Officials from New Jersey Medicaid informed us that primarily pediatricians and neurologists use these codes.²⁸⁸

Unlike primary care physicians, social workers and counselors cannot bill Medicaid directly. The list in the regulations of providers eligible to participate in Medicaid does not include counselors or social workers.²⁸⁹ The chart in the waiver proposal setting forth covered behavioral health services similarly omits them.²⁹⁰ A September 2013 newsletter discussing the requirement that social workers who wish to refer their clients for services covered by Medicaid first register as “non-billing providers” makes it clear that social workers are not eligible to enroll in Medicaid as independent providers.²⁹¹

http://www.state.nj.us/humanservices/dmahs/home/NJ_1115_Demonstration_Comprehensive_Waiver_9-9-11.pdf.

²⁸⁵ *Id.* at 110.

²⁸⁶ *Id.* at 99.

²⁸⁷ See NJMMIS, Medicaid Fee for Services: Update July 1, 2014, <https://www.njmmis.com/downloadDocuments/CPTHCPSCODES.pdf> (last visited July 29, 2015).

²⁸⁸ In our conversations in connection with this Report, we did not learn whether Medicaid would pay a claim submitted by a MHP for services provided by an employed primary care provider for physical health services.

²⁸⁹ N.J.A.C. § 10:49-3.1(b)(1).

²⁹⁰ COMPREHENSIVE WAIVER, *supra* note 284, at 109-12.

²⁹¹ State of New Jersey Department of Human Services, Division of Medical Assistance & Health Services, Recognizing Social Workers as ‘Non-Billing’ Providers, Vol. 23, No. 16, at 1, *available at* <https://www.njmmis.com/downloadDocuments/23-16.pdf>.

Although social workers and counselors cannot bill Medicaid directly, if they work in an independent clinic that can bill Medicaid, the clinic can bill for their services, with the caveat that “unless licensure or certification provisions permit otherwise, counseling or therapy services shall be provided by individuals with at least a masters degree in a recognized mental health discipline.”²⁹² A presentation prepared by a New Jersey Medicaid official indicates that “[s]ervices delivered by social workers, professional counselors, and other licensed healthcare professionals within their scope of practice are covered by NJ FamilyCare when delivered by qualified practitioners employed by NJ FamilyCare participating independent clinics and hospitals.”²⁹³ In addition, “[a]n agency licensed as an independent clinic can bill for services provided by a [certified alcohol and drug counselor (CADC), licensed clinical alcohol and drug counselor (LCADC)], or other qualified staff as per the independent clinic and substance abuse facility regulations.”²⁹⁴

It is difficult to find support in the regulations or elsewhere for differential treatment of licensed counselors and licensed social workers, apart from in the FQHC setting. As discussed above, the spreadsheet Medicaid disseminated to FQHCs limits reimbursement to behavioral health services provided by a psychiatrist, a psychologist, an advanced practice nurse, or an LCSW. The requirement that counselors or social workers have a master’s degree could be a barrier to integration, though, since masters-level staff command a higher salary than staff members without an advanced degree. Another potential barrier is that New Jersey does not reimburse clinics for services provided by peer counselors and other non-traditional providers.

D. Reimbursement for Services Central to Providing Integrated Care

1. Screening

In New Jersey’s 2011 waiver proposal, the State wrote that it envisioned “[r]outine screening of individuals in primary care settings to identify unmet BH needs, with expedited referrals to needed BH services[,]” as well as “[r]outine screening of individuals in BH settings to identify unmet medical needs, with expedited referrals to appropriate [physical health (PH)] services[.]”²⁹⁵ Medicaid managed care organizations (MCOs) would:

be required to implement a standardized protocol to identify common BH risks in primary care settings, provide necessary education and brief intervention in order to facilitate referrals of individuals who screen positive to an appropriately credentialed and qualified BH provider. This includes but is not limited to

²⁹² N.J.A.C. 10:37E-2.6(a)(1).

²⁹³ Kennedy, *supra* note 243.

²⁹⁴ *Id.*

²⁹⁵ COMPREHENSIVE WAIVER, *supra* note 284, at 99.

selecting appropriate screening tools and establishing provider requirements to follow the established screening and referral protocols, including the Screening, Brief Intervention and Referral to Treatment (SBIRT) protocol. The MCO will collaborate with [DMAHS and the organization chosen to manage behavioral health services] to establish a list of approved screening tools that are efficient to use and meet generally accepted standards for reliability (consistency of results) and two measures of validity: sensitivity (accuracy in identifying a problem) and specificity (accuracy in identifying individuals who do not have a problem).²⁹⁶

SBIRT “is an early intervention approach that targets individuals with nondependent substance use to provide effective strategies for intervention prior to the need for more extensive or specialized treatment.”²⁹⁷ It “differs from the primary focus of specialized treatment of individuals with more severe substance use, or those who meet the criteria for diagnosis of a substance use disorder.”²⁹⁸ SBIRT codes allow for reimbursement for services provided in a primary care setting to patients at risk of substance abuse. With the help of a SAMHSA grant, New Jersey is evaluating the SBIRT approach.²⁹⁹ In addition, providers can bill and be reimbursed by New Jersey Medicaid for providing SBIRT services.³⁰⁰

2. Care coordination and case management

As Mary Takach has explained, “[i]ntegrated care often involves the type of care coordination and provider collaboration that takes time and is not always billable through conventional fee-for-service systems.”³⁰¹ With limited exceptions, New Jersey Medicaid does not reimburse providers for care coordination or case management services.³⁰²

²⁹⁶ *Id.* at 100.

²⁹⁷ U.S. DEP’T OF HEALTH & HUMAN SERVS., CENTER FOR MEDICARE & MEDICAID SERVS., SCREENING, BRIEF INTERVENTION, AND REFERRAL TO TREATMENT (SBIRT) SERVICES (June 2014), available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/SBIRT_Factsheet_ICN904084.pdf.

²⁹⁸ *Id.*

²⁹⁹ SAMHSA, Screening, Brief Intervention, and Referral to Treatment (SBIRT) Grantees, <http://www.samhsa.gov/sbirt/grantees> (last visited July 29, 2015).

³⁰⁰ See NJMMIS Medicaid Fee for Services, *supra* note 287.

³⁰¹ TAKACH ET AL., *supra* note 771, at 2.

³⁰² See Kennedy, *supra* note 243, (explaining that “[c]ase management other than targeted case management rendered to consumers with severe mental illness (SMI) by DMHAS-qualified [integrated case management services (ICMS)] providers is not a NJFamilyCare covered service.”); Letter from Marilyn Tavenner, Acting Administrator, Centers for Medicare & Medicaid Services, to Jennifer Velez, Commissioner, Department of Human Services (Oct. 2, 2012) (stating that the federal government would support “[c] Community support and coordination services including behavioral health and medication assisted treatment to certain low income individuals 18 years and older with income up to and including 150 percent of the Federal Poverty Level (FPL) who have a mental illness and an opioid addiction diagnosis.”).

In New Jersey’s 2011 waiver proposal, the State indicated that MCOs would establish “financial incentives for [behavioral health-physical health] coordination activities in the primary care setting (*i.e.*, submitting the BH screening tool to the MCO, developing care coordination capacity within a primary care practice for enrollees with chronic diseases and BH co-morbidities, or co-location of BH and PH specialists).”³⁰³ The waiver also indicated that for the “highest risk individuals”, the MCO and Administrative Service Organization (ASO)/Managed Behavioral Healthcare Organization (MBHO) will collaborate with regard to, among other things, care coordination.³⁰⁴ Care coordination can include, among other things, “[t]raining of PCP and BH providers on screening, referral and co-management and training of [primary care providers (PCPs)] on [evidence-based practices (EBPs)] for BH conditions commonly treated in primary care settings[,]” “[a]n enrollee consent form to be used by both PH and BH providers for sharing information among primary care/specialty and BH providers[,]” and “[d]evelopment and implementation of an integrated clinical record necessary to support BH-PH coordination, in accordance with applicable privacy laws[.]”³⁰⁵

There are encouraging pilots in the State that involve elements of integration. For example, officials from Medicaid told us about a program at Morristown Memorial Hospital that pays a care management fee to the hospital for behavioral health services for the developmentally disabled population. The State also launched a behavioral health home pilot program in 2014.³⁰⁶ The State is in the process of resolving whether and to what extent to “carve out” or “carve in” behavioral health services in its ASO and MCO contracts. This decision will clearly have substantial effect on the integration discussion.

3. Brief and same-day services

Many believe that for integrated care to succeed, it is important to be able to respond rapidly to identified behavioral health needs.³⁰⁷ For this reason, prior authorization requirements have the potential to be a barrier to care. This does not seem to be an issue in New Jersey Medicaid, though. There is a prior authorization requirement for mental health services, but it is not triggered until “payment to an independent clinic exceeds \$6,000 for [a] Medicaid or NJ FamilyCare fee-for-service beneficiary in any 12-month period, commencing with the beneficiary's initial visit.”³⁰⁸

³⁰³ COMPREHENSIVE WAIVER, *supra* note 284, at 42-44.

³⁰⁴ *Id.* at 105.

³⁰⁵ *Id.*

³⁰⁶ See State of N.J. DEP’T OF HUMAN SERVCES., DIV. OF MENTAL HEALTH & ADDICTION SERVCES., *Health Homes*, <http://nj.gov/humanservices/dmhas/initiatives/integration/hh.html> (last visited Sept. 8, 2015).

³⁰⁷ See, *e.g.*, HOUY & BAILIT, *supra* note 62, at 1.

³⁰⁸ N.J.A.C. § 10:66-1.4. See NJMMIS Medicaid Fee for Services, *supra* note 287.

Under certain circumstances, New Jersey also allows reimbursement for multiple services provided on the same day.³⁰⁹ There is no statutory or regulatory bar to receiving physical health care services from one health care professional and mental health care services from another in the same day. Some providers interviewed by the authors reported that an issue can arise when a beneficiary receives services from a psychiatrist and another physician in the same day. In 2013, the coding for services provided by psychiatrists in ambulatory settings was switched from procedure codes such as 90862 (“Pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy”) to evaluation and management codes identical to those used by all other physicians. If a patient is seen by a primary care physician and a psychiatrist on the same day, it may appear that he or she received duplicative services. Medicaid may then reimburse the provider for “the first one that hits” and deny the second. We also were told that providers could avoid a denial in this situation if they used a modifier to make it clear that two distinct services were provided, although the modifier would trigger a reduced reimbursement rate.

In the FQHC setting, there is no bar on beneficiaries receiving one medical encounter and one psychiatric encounter in the same day. Beneficiaries can even receive two medical encounters in the same day, if “the beneficiary is seen by more than one licensed practitioner for the prevention, treatment or diagnosis of different injuries or illnesses, and practitioners of appropriate different specialties are involved.”³¹⁰

But generally, Medicaid’s billing system will not pay for two services provided by the same provider on the same day. One exception, as discussed above, is when eligible physicians are permitted to bill codes 90833 or 90836 in conjunction with E&M codes for psychotherapy provided in the course of providing physical health care services.

Similarly, the mental health clinic regulations provide that “[o]nly one type of mental health service per beneficiary shall be reimbursable to an independent clinic per day, with the following exception: 1. Medication management may be reimbursed when provided to a Medicaid or NJ FamilyCare fee-for-service beneficiary in addition to one of the following mental health services: individual psychotherapy, group psychotherapy, family therapy, and family conference.”³¹¹

It is important to note, however, that New Jersey Medicaid does not presently reimburse FQHCs for group therapy. As discussed above, Medicaid representatives indicated openness to revisiting the issue if an alternative payment methodology could be worked out to determine a fair level of reimbursement.³¹²

³⁰⁹ HOUY & BAILIT, *supra* note 62, at 14.

³¹⁰ N.J.A.C. § 10:66-4.19(a)(2)(i).

³¹¹ *Id.* § 10:66-2.7(b).

³¹² See *supra* note 258 & accompanying text.

Medicaid officials also indicated that they are working to construct something akin to a bundled code that would permit reimbursement at an enhanced rate for more than one behavioral health service in one day when more intensive services are clinically appropriate.

It can also be important to the sustainability of integrated models of care that providers are able to be reimbursed for services provided for very short periods of time. The evaluation and management codes that physicians use to bill for their services allow for billing increments of five minutes.³¹³ The Health and Behavior Assessment and Intervention (HBAI) codes, which behavioral health providers can use to bill for services to clients who do not have a behavioral health diagnosis but rather have behavioral health needs arising out of or impacting a physical health problem, allow for billing in increments of 15 minutes.³¹⁴ By contrast, the spreadsheet that DMAHS circulated to FQHCs includes codes for 20-30 minutes of psychotherapy and codes for 45-50 minutes of psychotherapy, longer periods of time than are contemplated by the most widely-known integrated care models. Medicaid officials informed us that private physicians as well as physicians employed by FQHCs are permitted to bill using HBAI code 96150 for the initial assessment. We were informed that only psychologists may use additional HBAI codes, including 96151 for reassessment, 96152 for individual treatment, 96152 for individual treatment, 96153 for family treatment with the patient, and 96154 for family treatment without the patient.

4. Telepsychiatry

New Jersey allows Medicaid payment for telepsychiatry “for the face to face provision of mental health services provided by psychiatrists and psychiatric advance practice nurses at independent clinic mental health programs and hospital outpatient mental health programs[.]”³¹⁵ Medicaid must approve the provider to ensure that patient confidentiality, for example, is preserved, but once approved, these services are reimbursable, except for group therapy. In a newsletter announcing this policy, DMAHS indicated that it “hopes to ameliorate the difficulties that providers have expressed in obtaining qualified medical directors and access to psychiatric services.”³¹⁶ Telepsychiatry could also be used as part of an integrated care model, to improve the quality of the behavioral health care being provided in primary care settings. Officials from Medicaid confirmed to us that telepsychiatry services are not reimbursable in other settings, including FQHCs.

³¹³ See American Academy of Pediatrics, Using Time as the Key Factor for Evaluation and Management Visits, <https://www.aap.org/en-us/professional-resources/practice-support/Coding-at-the-AAP/Pages/Using-Time-to-Report-Outpatient-EM-Services.aspx> (last visited July 30, 2015).

³¹⁴ See NJMMIS Medicaid Fee for Services, *supra* note 287.

³¹⁵ State of New Jersey Department of Human Services, Division of Medical Assistance & Health Services, Telepsychiatry, Vol. 23, No. 21, at 1, available at <https://www.njmmis.com/downloadDocuments/23-21.pdf>.

³¹⁶ *Id.*

E. Billing Issues Related to Choice of a Diagnosis Code

Like many other states, New Jersey Medicaid carves out behavioral health care.³¹⁷ This creates confusion for providers trying to provide integrated care to individuals with physical and mental health diagnoses in need of both kinds of care.

Interviewees raised the issue of “1378” rejections. These denials of payment occur when an FQHC includes both behavioral health and physical health diagnosis and procedure codes on its claim for a single encounter. Although the facility is billing for a single encounter at the PPS rate, it includes both the physical and behavioral health codes on the claim to accurately reflect the services it rendered during the encounter. For example, an FQHC submits a claim to a Medicaid HMO and the first diagnosis code listed is for a physical health condition, and the second diagnosis code is for a behavioral health condition. Or, vice versa, an FQHC submits a claim to Medicaid fee-for-service with the first diagnosis code for a behavioral health condition and the second for a physical health condition.³¹⁸

We were informed by a DMAHS interviewee that if an FQHC chooses to use the physical health encounter code, the first *two* diagnosis codes and the first *two* procedure codes have to be physical health-related (or in any event not specific to behavioral health); an FQHC may only list the behavioral health code third. If the FQHC chooses to use the behavioral health billable encounter code, the inverse is true. Claims that violate this procedure are rejected using code “1378,” even though the services individually and in combination are reimbursable.

This policy obviously creates both clinical and billing difficulties for FQHCs and their providers. A clinician may feel justified or obligated to make two diagnoses, one for a physical health condition, and one for a behavioral health condition, but she may not have diagnosed a second physical or behavioral health condition. The facility and its clinicians can face difficulty in squaring medical record-keeping norms and professional ethics with these billing conventions. State representatives were unable to explain why (and perhaps whether) DMAHS adheres to such a set of counterintuitive and potentially disruptive principles after several inquiries.

F. The Challenge to Sustainability Posed by Low Reimbursement Rates

Although beyond the scope of this Report, it must be noted that Medicaid payment rates for behavioral health services are in many circumstances quite low.³¹⁹ In addition, New Jersey,

³¹⁷ DEBORAH BACHRACH, STEPHANIE ANTHONY & ANDREW DETTY, STATE STRATEGIES FOR INTEGRATING PHYSICAL AND BEHAVIORAL HEALTH SERVICES IN A CHANGING MEDICAID ENVIRONMENT 7 (Aug. 2014) (“[F]ew states offer integrated benefits in managed care; most ‘carve out,’ or create separate reimbursement streams for at least some behavioral health services.”).

³¹⁸ Molina Medicaid Solutions, Edit Code Information, <https://www.njmmis.com/editCodeSearch.aspx> (last visited July 30, 2015 (“This edit posts to FQHC claims if the procedure code on the claim is W9820 instead of T1015 HE and the primary diagnosis code is a psychiatric diagnosis.”)).

³¹⁹ In his State of the State Address on January 12, 2016, Governor Christie proposed spending an additional \$100 million for mental health and substance use disorder services “to provide more competitive reimbursement rates for services and providers.” The Address did not describe how the additional funds would be added to current

in common with other states, currently pays for behavioral health services through a combination of a State-funded contract amount agreed upon with a provider, and payments through the Medicaid system. The State is currently working towards a reorganization of the payment systems to rely more heavily on Medicaid payments. That shift appears to have the benefit of bringing more federal funds to the behavioral health service delivery system. It will be a jarring change, however, for many service providers who have organized their business models around contractual payments rather than Medicaid payments. DHS hopes, however, that this shift will advance the cause of behavioral health integration.³²⁰

DHS is engaged in a process of moving reimbursement methods for both mental health and substance use disorder care. One component of that shift was the launching of an arrangement with Rutgers University Behavioral Health Care to perform services as an “interim managing entity” for substance use disorder treatments on July 1, 2015. Further development of payment systems is under way at DHS.³²¹

In whatever system eventuates, the State is obligated under federal law to “assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available . . . at least to the extent that such care and services are available to the general population.”³²² Part of the discussion of the “efficiency” and “quality” aspects of that discussion should be to incorporate the analysis cited above that properly integrated behavioral health care can both improve patient outcomes and be cost-neutral or even cost-saving.³²³

V. Analysis and Recommendations

The need to integrate behavioral and physical health services is undeniable. As we prepared this Report, we confronted conflicts and confusion over many issues; we have suggested resolutions of many of those conflicts and have attempted to dispel much of the confusion. We did not, however, find significant opposition to the imperative to reverse the deep historical separation between primary health care on the one hand, and mental health and substance use disorder care on the other.

payment systems; that level of detail will presumably appear as the proposal is considered in legislative and budgetary processes. See State of New Jersey, Office of Governor Chris Christie, Governor Chris Christie’s 2016 State of the State Address As Prepared for Delivery (January 12, 2016) *available at* <http://www.state.nj.us/governor/news/addresses/2010s/approved/20160112.html>.

³²⁰ Andrew Kitchenman, *State Shifts Way It Pays for Medicaid Mental-Health, Addiction Treatments*, NJSPOTLIGHT (May 1, 2015), <http://www.njspotlight.com/stories/15/04/30/state-shifts-way-it-pays-for-medicaid-mental-health-addiction-treatments/>.

³²¹ See Letter from Lynn A. Kovich, Assistant Commissioner, Division of Mental Health and Addiction Services to Provider (Apr. 27, 2015), *available at* http://www.nj.gov/humanservices/dmhas/initiatives/managed/IME_Implementation_Phases_Ltr.pdf.

³²² 42 U.S.C. § 1396a(a)(30)(A).

³²³ See *supra* Parts II(A) and (B).

The reasons for the push to advance the cause of behavioral health integration are many, but three predominate. First, the evidence has been growing for decades that reducing or eliminating the separation between physical and behavioral health services is clinically indicated. As is more fully described in Parts I and II above, for example, people with serious mental illness suffer shockingly higher mortality and morbidity as a result of poorly managed chronic physical illness, with some reports estimating that people with serious mental illness die as much as twenty-five years younger than population norms. In addition, as is also described above, it is clear that less severe behavioral conditions, including depression, anxiety, and substance use disorders, often go undiagnosed and treated for lack of capacity and expertise in primary care settings. In sum, clinical best practices point the way to integrating previously separate modes of care to improve patient well-being.

Second, as is described in Part II(C) above, there is a growing body of literature indicating that integrating care is cost-neutral or cost-saving. The provision of behavioral health care to patients in treatment for physical health conditions has been found to more than pay for itself in significant reductions in the cost of physical health care.³²⁴ In particular, a recent study in New Jersey suggests that a large percentage of high-cost hospitalizations are related to behavioral health conditions more appropriately treated on an outpatient basis, suggesting that the provision of appropriate behavioral health care in conjunction with primary or chronic physical health care could reduce the costs reflected in emergency department or inpatient usage by frequent utilizers of hospital care.³²⁵ Controlled studies of patients treated by collaborating behavioral health and primary care professionals have shown net reductions in care after initial start-up costs.³²⁶

There is a third reason for pursuing integrated care that may be less obvious, but was frequently raised in our conversations. Most patients with mild to moderate behavioral health conditions are seen in primary care settings for their behavioral health care.³²⁷ There are, of course, many reasons for this: the behavioral condition may be undiagnosed; the patient may prefer, for reasons having to do with convenience and perceived stigma, to receive care in a primary care setting; and the behavioral health system is fragmented, underfunded, and can be difficult to access, particularly for low-income persons.³²⁸ Without diminishing the difficulties faced by non-poor consumers as they attempt to obtain behavioral health services, the plight of low-income consumers is more serious. A partial solution to access concerns for those with mild or moderate behavioral health issues in this population is to enable the primary care providers

³²⁴ See *EVOLVING CARE*, *supra* note 10, at 27.

³²⁵ See *supra* text at notes 39-41.

³²⁶ See *supra* text at notes 43-56.

³²⁷ See *infra* Part II(A).

³²⁸ See *id.* See also REPORT OF A SURGEON GENERAL'S WORKING MEETING ON THE INTEGRATION OF MENTAL HEALTH SERVICES AND PRIMARY HEALTH CARE, UNITED STATES DEPARTMENT OF HEALTH AND SENIOR SERVICES, OFFICE OF THE SURGEON GENERAL (2001), available at <http://www.ncbi.nlm.nih.gov/books/NBK44335/>; PRIMARY CARE PROVIDERS' ROLE IN MENTAL HEALTH, BAZALON CENTER (undated), available at <http://www.bazelon.org/LinkClick.aspx?fileticket=CBTKUhxTlvw%3D&tabid=220>.

to which they have access – in particular, FQHCs – to serve the role of integrated care provider to which people with more means have imperfect but more substantial access.

We address below three central integration-related issues we identified in the course of our research and conversations: the means by which clinical integration should be structured; the steps that we recommend for adjusting the State’s licensure system to facilitate appropriate integration; and how payment issues may be considered as behavioral health integration moves forward.

A. Clinical Models of Integration

Health systems researchers have described a wide variety of integration models, and an equally diverse array of licensure and payment structures to accommodate those models. One approach to integration is to embed a behavioralist in a primary physical health care team. This is the approach taken by, among others, Cherokee Health Systems, in Tennessee,³²⁹ and by six federally qualified health centers in Oregon that are participating in that state’s Alternative Payment Methodology pilot project.³³⁰ In a number of participating clinics in Oregon, “physicians can now immediately refer patients to these behavioral health clinicians in a ‘warm handoff,’ meaning the physician introduces the patient to the specialist in the clinic at the end of the visit.”³³¹ With support from The Nicholson Foundation, the Cherokee Health System’s model also is being used at two FQHCs in New Jersey, The Center for Health Education, Medicine, & Dentistry (CHEMED) in Lakewood,³³² and the Henry J. Austin Health Center in Trenton.³³³ A second approach to integration is to embed a physical health care provider on a behavioral health care team. Here in New Jersey, CarePlus developed an on-site primary physical health care practice so that it could better serve its clients with serious mental illness and substance use disorders.³³⁴

³²⁹ *Id.* at 142.

³³⁰ Deborah Cohen, *Addressing Behavioral Health Integration with Payment Reform*, HEALTH AFFAIRS BLOG, <http://healthaffairs.org/blog/2015/04/20/addressing-behavioral-health-integration-with-payment-reform/> (Apr. 20, 2015).

³³¹ *Id.*

³³² See THE NICHOLSON FOUNDATION, INSPIRE (Integrating Networks and Systems to Achieve Patient Healthcare Integration Reform Effectively): Center for Health Education Medicine and Dentistry (CHEMED) - See more at: <https://thenicholsonfoundation.org/what-we-do/projects/inspire-integrating-networks-and-systems-achieve-patient-healthcare-integration#sthash.qCrqB78j.dpuf>, <https://thenicholsonfoundation.org/what-we-do/projects/inspire-integrating-networks-and-systems-achieve-patient-healthcare-integration> (last visited Dec. 10, 2015).

³³³ See THE NICHOLSON FOUNDATION, Integrating Care to Reduce Health Disparities in a Medical Home: Trenton Health team, <https://thenicholsonfoundation.org/what-we-do/projects/integrating-care-reduce-health-disparities-medical-home> (last visited Dec. 10, 2015).

³³⁴ Beth Fitzgerald, *CarePlus NJ Establishes First State-Certified Behavior Health Home Agency*, NJBIZ.COM (May 27, 2015).

Ron Manderscheid and Roger Kathol have argued in favor of what they characterize as a third approach to integration.³³⁵ Under their approach, behavioral health is treated like any other area of health addressed through a “primary care health home.” Most patients with behavioral health conditions, approximately 90%, would “be seen in primary and specialty medical settings in which BH is a core part of delivered services.”³³⁶ The remaining 10% of patients would receive services in a specialty behavioral health setting “that, like other medical specialty settings, has ready access to collaborative general medical services for its patients when needed.”³³⁷

There are a number of steps states can take to support integration through regulation. For example, the state of Missouri is “developing fee-for-service payments for screening and assessment of mental health and substance abuse needs, and for brief behavioral health interventions in primary care settings.”³³⁸ Providers in the state will be able to “bill for more intensive evaluation and management procedure codes if they deliver behavioral health services during the same visit as primary care services.”³³⁹

Medicaid health homes are another approach to compensating providers for the “difficult to reimburse” services that are central to the provision of integrated care.³⁴⁰ New Jersey has been approved to offer two models of integrated health homes, one for adults with serious mental illness, and one for children with serious emotional disturbance.³⁴¹ The program will begin on a pilot basis in Bergen County, but the State anticipates rolling out Medicaid health homes statewide. In the context of the “health home,” providers will be compensated for comprehensive care management, care coordination, health promotion, comprehensive transitional care and follow-up, individual and family support, and referral to community and social support services.³⁴²

New Jersey also has received a planning grant award from SAMHSA for the current federal fiscal year to plan and develop Certified Community Behavioral Health Clinics (CCBHCs).³⁴³ CCBHCs aim to provide improved coordination and integration of care, with a particular focus on

³³⁵ Manderscheid & Kathol, *supra* note 4, at 62.

³³⁶ *Id.*

³³⁷ *Id.*

³³⁸ Shayla Regmi & Andrew Snyder, *Using Payment Policies to Support Primary Care – Behavioral Health Integration in Medicaid*, STATE HEALTH POLICY BLOG (Aug. 2014), <http://www.nashp.org/using-payment-policies-support-primary-care-behavioral-health-integration-medicaid/>.

³³⁹ *Id.*

³⁴⁰ HEALTH HOME INFORMATION RESOURCE CENTER, CENTERS FOR MEDICARE & MEDICAID SERVICES, MEDICAID HEALTH HOMES: AN OVERVIEW (2015), available at <http://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-homes-technical-assistance/downloads/medicaid-health-homes-overview.pdf>.

³⁴¹ New Jersey Medicaid State Plan Amendment #14-0006, available at <http://www.medicaid.gov/state-resource-center/medicaid-state-plan-amendments/downloads/nj/nj-14-0006.pdf> (last visited Oct. 15, 2015); New Jersey Medicaid State Plan Amendment #14-0005, available at <http://www.medicaid.gov/state-resource-center/medicaid-state-plan-amendments/downloads/nj/nj-14-0005.pdf> (last visited Oct. 15, 2015).

³⁴² *Id.*

³⁴³ See N.J. Dept’ of Human Servcs., Div. of Mental Health & Addiction Servcs., Certified Community Behavioral Health Clinics: CCBHCs Stakeholders, at 2 (Oct. 2015) (PowerPoint slides on file with authors) [hereinafter CCBHC Webinar].

“adults with serious mental illness, children with serious emotional disturbance, and those with long term and serious substance use disorders, as well as others with mental illness and substance use disorders.”³⁴⁴ During the planning year, the State, among other things, will develop a CCBHC certification process and a Medicaid prospective payment system.³⁴⁵ As a recipient of a planning grant, New Jersey is eligible to apply to be one of up to eight states that will participate in the demonstration phase of the grant.³⁴⁶

Blount and others have opined that “[m]erging funding streams so that all health care plans pay for medical and mental health care from the same pot of money is the long-term goal that would structurally align incentives for collaborative care.”³⁴⁷ Tennessee is an example of a state that “requires managed care contracts that include integrated medical and behavioral health care.”³⁴⁸ In a 2014 policy brief, Deborah Brown and Tricia McGinnis offer the example of Hennepin Health, “a safety-net ACO in Minnesota, [which] has successfully integrated medical services with behavioral health services (and other county-funded and social services).”³⁴⁹ Brown and McGinnis explain that Hennepin Health “receives a capitated payment, which encourages providers to work with one another to coordinate care for patients, thereby reducing duplicative and costly treatments and maximizing providers’ net income.”³⁵⁰

Brown and McGinnis note that financing mechanisms short of global capitation, such as “a shared savings payment tied to a set of cost and quality measures may be sufficient to propel providers to coordinate physical and behavioral health services.”³⁵¹ They cite as an example the state of Maine, which is going to include behavioral health services within the total cost of care calculation (TCOC) for its Accountable Communities.³⁵² If an Accountable Community’s TCOC is at least two percent below benchmark, it will be eligible for shared savings.³⁵³ It is hoped that this will “promote shared accountability across historically siloed primary care and behavioral health providers.”³⁵⁴

The state of Tennessee has taken a number of additional steps to facilitate integration. The state pays for SBIRT billing codes, allows same-day billing, and “has allowed the development

³⁴⁴ SUBSTANCE ABUSE AND MENTAL HEALTH SERVCES. ADMIN., Planning Grants for Certified Community Behavioral Health Clinics, <http://www.samhsa.gov/grants/grant-announcements/sm-16-001> (last visited Dec. 10, 2015).

³⁴⁵ See CCBHC Webinar, *supra* note 343, at 2.

³⁴⁶ See *id.* at 2.

³⁴⁷ Blount *et al.*, *supra* note 36, at 294.

³⁴⁸ TAKACH, *supra* note 771, at 3.

³⁴⁹ Deborah Brown & Tricia McGinnis, *Considerations for Integrating Behavioral Health Services within Medicaid Accountable Care Organizations*, CENTER FOR HEALTH CARE STRATEGIES 3 (2014). Brown and McGinnis also note that Oregon “is now using regional Coordinated Care Organizations to manage both physical and behavioral health benefits for Medicaid beneficiaries under a global budget[.]” *Id.*

³⁵⁰ *Id.*

³⁵¹ *Id.*

³⁵² *Id.*

³⁵³ *Id.*

³⁵⁴ *Id.*

of and payment for a new category of behavioral health workers, known as certified peer specialists[.]”³⁵⁵ On the licensing front, Tennessee’s “Commissioner of the Department of Mental Health and Developmental Disabilities ruled that a Federally Qualified Health Center (FQHC) or primary care clinic may deliver behavioral health services without being licensed as a Community Mental Health Center (CMHC).”³⁵⁶

Even very small steps could have a significant impact. A group of experts convened by the Substance Abuse and Mental Health Services Administration (SAMHSA) emphasized “the need to clarify policies, definitions, and services, and broadly disseminate the clarifications.”³⁵⁷ California “has created a website with detailed instructions on how to use billing codes to support integration.”³⁵⁸ Maine has “developed a billing and payment guide for integrated care practices.”³⁵⁹ States that “have developed state-specific insurance coding sheets to assist integrated care sites in billing for services . . . have reported success in helping providers recover some of the costs of integrated care services.”³⁶⁰

This overview of integration models informs our analysis of a concern highlighted by several of those we interviewed, including representatives of regulators. The concern was expressed that it would be either necessary or helpful for there to be produced a description, or taxonomy, of the discrete levels of behavioral conditions appropriate for integrated settings. It was suggested that regulatory responses to the call for integrated care require or would be aided by clear “lines of demarcation” among levels of care required for patients with more or less intense needs for services. Categories suggested by various interlocutors included the separation of levels of care into “primary” and “specialty” behavioral health care. Also suggested was a separation of care for patients with “mild or moderate” symptoms, or those with “severe” or “severe and persistent” symptoms.

The concerns motivating this desire for precision and predictability are important ones. First, the principal agencies involved in the licensure and oversight of care have distinct areas of expertise – DHS in behavioral health, and DOH in physical health. Lines of demarcation, therefore, would serve institutional interests and avoid inefficient or overlapping bureaucracy. Second, a clear allocation of types of services to identified professionals and/or facilities is a powerful tool for Medicaid, as it attempts to control responsibly the size of the budget devoted to various types of care. If a particular procedure can be done only in a particular type of facility for clinical reasons, it makes sense for Medicaid to restrict *payment* for that service only when provided in such a facility.

³⁵⁵ TAKACH ET AL., *supra* note 771, at 3.

³⁵⁶ *Id.*

³⁵⁷ DANNA MAUCH, CORI KAUTZ & SHELAGH SMITH, REIMBURSEMENT OF MENTAL HEALTH SERVICES IN PRIMARY CARE SETTINGS, SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION 3 (2008).

³⁵⁸ HOUY & BAILIT, *supra* note 62, at 18.

³⁵⁹ COLORADO REPORT, *supra* note 62, at 31.

³⁶⁰ *Id.* at 7.

We reluctantly conclude that no simple lines of demarcation exist, nor is it likely that they could be developed. In physical health care, the concepts of “primary” and “specialty” care have meaning and usefulness in terms of procedure/billing codes and as a guide for the setting likely to be appropriate for the provision of that care. But primary care physicians on occasion appropriately perform specialty care, and specialists on occasion appropriately perform primary care, each incidental to the core services those professionals ordinarily provide. The separation of primary and specialty care is of great conceptual value, but the separation does not provide clean lines of demarcation as to the settings, or often even the professionals, most appropriate for care in any particular instance.

Similarly, people with mild/moderate behavioral health concerns could be seen either in an outpatient behavioral health setting suitable for such care, or in a primary physical health setting with suitable behavioral health professionals on hand. People with severe symptoms, on the other hand, would most appropriately be seen by highly specialized behavioral health professionals, although their physical health needs should, for the reasons described in this Report, be treated by primary care providers in that setting also. Looking at the issues from the patient’s perspective further elucidates the fluidity and complexity of the arrangements appropriate to patients’ needs.

Integrating behavioral and primary care is vitally important in different ways for different populations. First, many people with mild or moderate behavioral health conditions would benefit from care integrated at a primary care office. Primary care-based integrated care takes advantage of the fact that most behavioral health care is now provided in such a setting;³⁶¹ it reflects the fact that the symptoms of, and care for, physical health and behavioral health conditions are often interwoven;³⁶² primary care integration can increase access, particularly in low-income and minority communities served by FQHCs;³⁶³ it lessens the stigma created by separate facilities;³⁶⁴ and it enhances the likelihood of continuity of care.³⁶⁵ The value, then, of integrated care in a primary care setting includes the likelihood that adherence and follow-through by the patient will be improved if care is available in a single setting, and the chance for quality and outcomes enhancement if the care of patients with both physical and behavioral conditions can be coordinated.

A second cohort of patients that could benefit from integrated care comprises those with more severe mental illness. People in this population are likely to be consumers of specialized mental health services. However, as is described above in Part I, they are also likely to have significant, poorly managed physical health conditions. Integration of care for this group of

³⁶¹ See UNÜTZER, ET AL., *THE COLLABORATIVE CARE MODEL*, *supra* note 47.

³⁶² *EVOLVING CARE*, *supra* 10, at 3.

³⁶³ Alan K. Koike, *Ethnic Disparities in Unmet Need for Alcoholism, Substance Abuse, and Mental Health Care*, 158 *AM. J. PSYCHIATRY* 2027 (2002).

³⁶⁴ *EVOLVING CARE*, *supra* note 10, at 3.

³⁶⁵ See *generally supra* Part II(B).

patients is likely best achieved in a specialty mental health facility or through specialty mental health providers, who collaborate and coordinate with primary medical services.³⁶⁶ The enormous gain for this group is the chance to address the devastatingly high levels of excess morbidity and mortality experienced, as a result of poorly treated chronic physical illnesses, among people with serious mental illness.³⁶⁷

It is useful to consider these two foci for integration as New Jersey's regulatory process is reviewed. It is clear, however, that there are not simply two instances of practice in which integration is important, but rather a continuum of care along which patients move as their conditions – both physical and behavioral – change over time. Patients, therefore, are served more or less intensely over time by their various caregivers. People with long-term chronic physical illness such as coronary artery disease or seizure disorder often require intense physical health care over many years. Similarly, people with long-term chronic psychological conditions such as schizophrenia or bipolar disorder require care, often intense care, over the long-term from mental health professionals.

Consideration of the wide variety of conditions experienced by people with behavioral health conditions, and the fact that many people experience shifts in their need for different modalities of care over time, have led health systems researchers and clinicians to posit that allocation of clinical responsibility is best thought of functionally. That is, the appropriateness of the level of professional to provide care and the setting in which the care should be provided varies with the severity of behavioral and physical conditions experienced by patients at any point in time. A care delivery system that aspires to integrate physical and behavioral health care (and therefore a regulatory system that imposes licensure and payment structure on the system) must accommodate the messiness of a functional approach. The most widely-accepted functional approach is the “Four Quadrant” approach, which matches the needs of the patient to the level of care appropriate from behavioral and physical health providers, and suggests in what site the primary integration of care should take place. The model can be depicted as follows:

³⁶⁶ See Vidhya Alakeson *et al.*, *Specialty Care Medical Homes For People With Severe, Persistent Mental Disorders*, 29 HEALTH AFFAIRS 867, 868 (2010); Unützer *et al.*, *Transforming Mental Healthcare*, *supra* note 26, at 37, 39-40.

³⁶⁷ See, *e.g.*, Joseph P. McEvoy *et al.*, *Prevalence of the Metabolic Syndrome of Patients with Schizophrenia*, SCHIZOPHRENIA RESEARCH (Dec. 2005) at 19-32.

The Four Quadrant Model of Behavioral Health Integration³⁶⁸

<p><u>Quadrant II</u></p> <p>Patient characteristics:</p> <p>High behavioral health needs</p> <p>Low physical health needs</p> <p>Care setting:</p> <p>Served in mental health program with integrated primary care professionals</p>	<p><u>Quadrant IV</u></p> <p>Patient characteristics:</p> <p>High behavioral health needs</p> <p>High physical health needs</p> <p>Care setting:</p> <p>Served both in mental health program and primary care program with coordination by case manager</p>
<p><u>Quadrant I</u></p> <p>Patient characteristics:</p> <p>Low behavioral health needs</p> <p>Low physical health needs</p> <p>Care setting:</p> <p>Served in primary care setting with integrated behavioral health professionals</p>	<p><u>Quadrant III</u></p> <p>Patient characteristics:</p> <p>Low behavioral health needs</p> <p>High physical health needs</p> <p>Care setting:</p> <p>Served in specialty medical care practice and primary care setting with integrated behavioral health professionals</p>

Two conceptual tasks drive this model. First, the model describes a functional range of behavioral and physical health needs and accounts for the care appropriate to meet those needs. Second, it suggests a functional method for determining what the health “home” should be in any case, depending on the relative severity of the physical and behavioral conditions. The patient flow described in this clinical model of integration is widely accepted, and it describes the means by which health care providers of various specialties, each integrating a range of services appropriate for their professional settings, can manage the services of a patient over time.

As the Four Quadrant model emphasizes, sharp lines of demarcation among types of services are not feasible due to the smooth continuum of severity patients experience with respect to both physical and behavioral conditions. That said, New Jersey needs regulatory

³⁶⁸ Adapted from B. Mauer, *Behavioral Health/Primary Care Integration: The Four Quadrant Model and Evidence-Based Practices* (National Council for Community Behavioral Healthcare, 2006), available at <http://www.thenationalcouncil.org/galleries/business-practice%20files/4%20Quadrant.pdf/>; EVOLVING CARE, *supra* note 10.

guidance for each component part described in the Four Quadrant model. It refers to a “primary care setting with integrated behavioral health professionals” and a “mental health program with integrated primary care professionals.” Regulators by profession are charged with making the abstract concrete. In New Jersey, regulators have embraced the challenge of setting out the terms by which facilities can fulfill the mission set out in the Four Quadrant model.

In the following two Subparts, we discuss the means by which regulators can lower the barriers to integration through modest modifications to current regulatory practices in the licensure and payment areas.

B. Licensure Reform

Licensure regulations should be changed to reflect the broad clinical consensus that patients benefit from behavioral health integration. As we describe in Parts II(B) and (C) above, there is a growing body of literature identifying the dangers presented by a fragmented health care system, and the ameliorative effects produced by integrating physical and behavioral health services. Recently, a Supplement of the Journal of the American Board of Family Medicine was devoted to behavioral health integration.³⁶⁹ As one of the articles in that Supplement summarized,

In 2006, the Institute of Medicine and National Academy of Sciences issued a report in the Quality Chasm Series on Mental Health and Substance Use Disorders. The recommendation was clear: to achieve quality health care, mental health and substance use disorders must be integrated into health care. *** [T]here is strong evidence that patient experience and outcomes improve and costs are contained when behavioral and medical problems are addressed together.³⁷⁰

The regulatory system lags the clinical advances. In the absence of substantial, compelling reasons for maintaining barriers to integration, regulatory change must reflect the reality of patient needs. We have discovered no such compelling reasons to delay regulatory evolution toward permitting – even perhaps encouraging – behavioral health integration.

The task we set for this Part must be made clear. We acknowledge the many difficult clinical and practice management details that must be worked through as integration becomes reality.³⁷¹ These clinical difficulties are ongoing, and will require a long period of internalization

³⁶⁹ 28 J. AM. BD. FAM. MED. S1 – S110 (Sept. – Oct. 2015). The Table of Contents of this Supplement is available at http://www.jabfm.org/content/28/Supplement_1.toc.

³⁷⁰ Deborah J. Cohen, *et al.*, *Understanding Care Integration from the Ground Up: Five Organizing Constructs that Shape Integrated Practices*, 28 J. AM. BD. FAM. MED. S7, S7-S8 (Sept. – Oct. 2015).

³⁷¹ See generally *id.*; Deborah J. Cohen *et al.*, *Integrating Behavioral Health and Primary Care: Consulting, Coordinating and Collaborating Among Professionals*, 28 J. AM. BD. FAM. MED. S21 (Sept. – Oct. 2015).

of new practice norms by treating professionals, and evolution of practice theory. That task is not within the scope of this Report.

This Report addresses the regulatory, and not the clinical, aspects of behavioral health integration. Regulatory practice provides structural architecture for professional and commercial activity, to protect consumers and advance the public interest. It does not, and cannot, prescribe professional practice at minute levels of detail. Instead, it provides boundaries and large-scale mandates within which sound professional practice may flourish consistent with the public policy goals of the state. The discussion that follows, then, provides recommendations for the design of that regulatory structure. The discussion addresses first regulatory change to effectuate integration in the primary care setting, and then regulatory change for the MHP setting.

New Jersey's current licensure practices presented two sets of barriers to behavioral health integration. First, the current overlapping regulations of the Department of Human Services and the Department of Health inhibit adoption of integration in both primary care facilities such as FQHCs and MHPs. Second, prior to the issuance of the Shared Space Waiver, DOH mandated in some situations very onerous and unnecessary physical facility separation between services for behavioral health and physical health. These two barriers are addressed in turn.

1. Single or dual licensure

The licensure barriers to integration in both primary care and mental health care settings are substantial. We conclude after a literature review and discussions with advocates, health care providers, and regulators that fostering behavioral health integration is in the public interest, and that current regulations impose impediments to that integration. Leadership of the Departments of Human Services and Health are committed to lowering these barriers in the primary care realm, and are engaged and thoughtful on the means by which they might facilitate movement in this important area. The two agencies have engaged in discussions over a long period of time. The publication of the Shared Space Waiver is tangible evidence of these efforts, and represents a significant step towards a licensure system more amenable to integrated behavioral and physical health care.

The larger issue raised by providers seeking to integrate care is the burden and complexity of obtaining licensure from both agencies for the same facility. Whether New Jersey should move toward a system requiring a single license for integrated physical and behavioral care implicates a fundamental regulatory process conundrum. On one hand, merging the current relevant licensure responsibilities for integrated facilities into one agency would simplify the process of providing clinically appropriate integrated care – a goal that is of the utmost importance for the advancement of the health of people with behavioral health needs. On the other hand, separate agencies exist in state government in order to allow the aggregation of technical expertise at a scale appropriate to the effective protection of the health and welfare of the public. Where there

is overlapping agency jurisdiction, it is always possible to argue for consolidation; but the urge to simplify the regulatory burden in one aspect of regulation must be counterbalanced with the importance of maintaining the centers of expertise represented by existing agencies. Areas of regulation can shift from one agency to another – senior services and long term care responsibility have shifted from the DOH to DHS, for example. But such shifts should take place carefully and with some degree of planning, in order to ensure continued vigilance over the public’s safety.

The case to move from a dual licensure to a single licensure regime is easily stated. Patients with mild to moderate symptoms of behavioral conditions could benefit from the integration of primary health care with behavioral health care. Many ACFs that provide primary care are interested in serving their patients by expanding their services to provide behavioral health care. Similarly, patients with severe mental illness, frequently served by MHPs, would gain better access to primary physical health care if the MHPs expanded their services to include primary care, and some MHPs are interested in doing so. Both sets of providers – ACFs and MHPs – formally are now required to be licensed by both DHS and DOH if they provide clinically appropriate integrated care. The requirement for both licenses presents daunting barriers to their adoption of sound care practices.

The counterweight to a shift to single licensure for integrated facilities concerns the practical limits of current agencies’ resources. The statutory provisions governing DOH would appear to permit the agency, were it to adopt appropriate regulations, to license facilities to provide both outpatient behavioral health and physical health care.³⁷² DOH asserts, with some justification, that it has neither the resources nor the expertise to craft appropriate regulatory language or oversee the operations of such combined services. DOH, in other settings however, does regulate behavioral health services. It currently licenses and oversees the operations of hospital-based inpatient and outpatient behavioral health services,³⁷³ and in that setting (in consultation with DHS) sets and enforces regulatory standards under a single license. It would seem, in any event, that no statutory change would be necessary for ambulatory care facility licensure regulations to be modified to permit single-license behavioral health integration within FQHCs and other primary care facilities. It may be, then, the DOH could similarly, in consultation with DHS, license and oversee the operations of primary care facilities adding behavioral health services.

A Bill currently pending before the New Jersey Legislature would take the additional step of *requiring* DOH to permit a primary care facility to “provide limited behavioral health care services under its ambulatory care facility license, without a license to operate a mental health program or a substance abuse treatment facility issued by the Department of Human

³⁷² See *supra* Part III(B)(1), citing, *inter alia*, N.J.S.A. § 30:9A-20(b).

³⁷³ See *supra* Parts III(A) and (B)(8).

Services.”³⁷⁴ The Bill would require DOH to promulgate regulations permitting such single-license integration, in consultation with DHS. The Bill is silent on the collaboration, if any, between the two agencies necessary and appropriate for the enforcement of the regulations. It is not clear that statutory authority is required for this change; current law appears to permit the agencies to collaborate to permit integration in primary care facilities through a single license.

Collapsing the requirement to a single license for MHPs adding primary care raises some concerns for both DOH and DHS. Both behavioral health and physical health programs are properly subject to regulations governing their staffing levels, supervision system, cleanliness of facilities, space available for operations, and other common features. The provision of physical health care, however, raises basic infection control issues not raised in the behavioral health setting. Facilities requirements such as the presence of sinks in examining rooms are significant concerns for the DOH, and do not arise as a matter of course for DHS licensure.

That said, DHS could, if necessary, obtain the expertise to regulate and inspect for compliance with infection-control requirements through consultation with and collaboration with DOH. It is clear that consultation and coordination with a sister agency is somewhat clumsy, but interagency cooperation and collaboration occur in New Jersey, and the “borrowing” of expertise from DOH on this score would seem to present only a minor regulatory burden. That such cooperation is feasible is evidenced by the interagency cooperation underlying the promulgation of the Shared Space Waiver.

The Shared Space Waiver addressed issues central to behavioral health integration. It is limited in an important way: it permits shared space for DOH-licensed facilities seeking a behavioral health license from DHS, but does not specifically address the reverse situation: the shared use of space for a MHP, licensed by DHS seeking to add primary care services. The sense of the collaboration between DOH and DHS that produced the Shared Space Waiver suggests that such additional sharing of clinical space would be acceptable to the two agencies. An explicit expansion of the Shared Space Waiver to reach that situation should occur.

The Shared Space Waiver – particularly should it be augmented as described above – goes a long way in lessening the burdens of dual licensure for facilities seeking to add behavioral health services while still maintaining a system of dual licensure. But it continues the requirement for dual licensure. It may be that the process that led to the publication of the Shared Space Waiver could point the way to further collaborations that could gradually evolve into a single licensure system.

³⁷⁴ NJ S-1710 (introduced Feb. 16, 2016, 217th Legislature), available at http://www.njleg.state.nj.us/2016/Bills/S2000/1710_I1.PDF.

Recommendation #1

New Jersey should move toward a system requiring only a single license for the operation of an integrated facility.

- **Interim steps advancing DOH and DHS toward a single licensure system, such as the collaboration leading to the Shared Space Waiver, should be undertaken to minimize the impediments to implementing clinically appropriate integrated facilities.**

2. “Keep separate” provisions of State licensure

Licensure requirements for ambulatory care facilities mandating separate or duplicative facilities, services, or records maintenance were singled out as a significant barrier by many of the program representatives with whom we spoke. The most frequently-mentioned barriers were those pertaining to facilities requirements.

The Shared Space Waiver³⁷⁵ eliminates many of the problematic physical plant issues for FQHCs and other ACFs seeking to add behavioral health services. The integration of physical and behavioral care takes place in other settings as well, and the effect of the Shared Space Waiver on those settings is not clear. For example, many people with serious mental illness receive the bulk of their care in MHPs, which ordinarily are licensed by DHS, but not DOH. MHPs, when they wish to add primary health services, have also reported barriers created by physical plant licensure issues. As is the case with ACFs seeking to add behavioral health services, MHPs seeking to add primary care services have faced “keep separate” mandates. While the sense of the Shared Space Waiver would seem to apply equally to MHPs adding primary care services, it does not, on its face, clarify the concerns of MHPs. There would, of course, be complications, as the sanitary requirements for physical health care sometimes necessitate facilities improvements, such as the addition of sinks in exam rooms for hand-washing. A clear statement of the extent of physical plant requirements for MHPs or outpatient substance use disorder treatment facilities seeking to add primary care would advance the goals of behavioral health integration in these contexts, as the Shared Space Waiver advanced those goals in the ACF setting.

A minimization of most of the separate facilities requirements is essential for several reasons. First, these provisions for separating the patrons of the behavioral health services from

³⁷⁵ See *supra* Part III(B)(9)(a).

those of the primary care services are inappropriate because they impede the integration movement. The two services are intended to treat the same patients. The goal is to have a patient coming to an FQHC for diabetes care also have access to a clinical social worker or psychiatric advanced practice nurse for anxiety disorder or depression. Regulations that segment a facility, imposing unnecessary barriers to the smooth coordination of services, should be minimized to apply only when there is a strong justification (as in the case of medical records for mental health consultation) for such distinct treatment.

Second, the separate treatment is in tension with the agencies' obligations under the Americans with Disabilities Act not to discriminate against people who have a disability, are regarded as having a disability, or have a record of a disability in access to services

Third, there is no compelling reason for the agencies to maintain requirements for separate treatment. The requirements appear to be artifacts of a prior era, when separate treatment of people with behavioral health conditions was seen as protecting them from stigmatizing contact, and providing them with specialized care in a safe setting. Current clinical wisdom drives the care equation in a completely different direction, counseling coordinated treatment, and encouraging mainstreaming of behavioral health services.

In sum, the "keep separate" regulations should be eliminated except where supported by compelling reasons such as federal statutory requirements. The agencies are clearly working together to reach such a result, and the Shared Space Waiver eliminates most or all concerns with regard to ACFs; we urge the agencies to apply the same integrative efforts to services provided in MHPs and outpatient substance use disorder treatment facilities.

Recommendation #2

Regulatory requirements for separation of behavioral and primary care services should be eliminated, as DOH accomplished with the Shared Services Waiver, except for those, such as records maintenance, required by law. Facilities regulations should be functional, encouraging shared space and services where not inconsistent with patient needs.

C. Payment Issues

People with behavioral health needs can benefit from the integration of primary and behavioral health care. Persons with serious and persistent mental illness receiving services from a specialized MHP, for example, are likely to experience increased morbidity and early mortality as a result of poorly controlled chronic physical illness due to uneven connections with primary health care. Other persons with mild or moderate behavioral health symptoms may fail to engage in beneficial behavioral health services as a result of the lack of proper diagnostic, treatment, or referral resources at their primary care provider's office.³⁷⁶ The literature supports a remedy for these shortfalls: "integrated care is essential to accomplishing the Triple Aim."³⁷⁷ This Subpart discusses payment adequacy, shifting roles of fiscal agents in Medicaid, the need to expand the services reimbursable under Medicaid, and the question of when a Change of Scope application for FQHC payment is warranted.

1. Rate adequacy

Determining which clinical configurations will best deliver integrated care is a work in progress, and may well vary depending on the population served and the professional resources available.³⁷⁸ However integrated care is best configured, it simply cannot be provided unless the payment stream for the provision of services is sustainable. Most of the providers with whom we spoke rely entirely or predominantly on public funding, and particularly on Medicaid. Many of these service providers struggle with the payment levels from Medicaid. This is not a new problem. Paul Applebaum, then President of the American Psychiatric Association, wrote about the funding concerns of mental health providers over a decade ago. He observed that, "[t]he shape of the solution to the slow starvation of the mental health system is not obscure. Adequate funding needs to be made available to cover the costs of care."³⁷⁹

Concerns with access to care are frequently raised and documented at the national level.³⁸⁰ The evidence on access to care in New Jersey has been mixed.³⁸¹ The relationship between payment rates and provider participation in Medicaid is complex;³⁸² but the amount of

³⁷⁶ See *supra* notes 2-4 & accompanying text.

³⁷⁷ W. Perry Dickinson, *Strategies to Support the Integration of Behavioral Health and Primary Care: What Have We Learned Thus Far?*, 28 J. AM. BD. FAM. MED. S102, 102 (Sept. – Oct. 2015). See also *supra* Part II(B).

³⁷⁸ See *supra* notes 12-15 & accompanying text; Cohen *et al.*, *Understanding Care Integration from the Ground Up*, *supra* note 370, at S18-19.

³⁷⁹ Paul S. Applebaum, *The "Quiet" Crisis in Mental Health Services*, 22:5 HEALTH AFFAIRS 110, 115-16 (2003).

³⁸⁰ See DHSS OFFICE OF THE INSPECTOR GENERAL, ACCESS TO CARE: PROVIDER AVAILABILITY IN MEDICAID MANAGED CARE 13 (December 2014) ("Our findings demonstrate significant vulnerabilities in provider availability, which is a key indicator for access to care."), available at <http://oig.hhs.gov/oei/reports/oei-02-13-00670.pdf>.

³⁸¹ See Joel Cantor, *Opinion: How Good is Access to Medicaid Services in NJ? Depends on Whom You Ask*, NJ SPOTLIGHT (February 20, 2015) (citing studies), available at <http://www.njspotlight.com/stories/15/02/19/opinion-how-good-is-access-to-care-for-medicaid-beneficiaries-in-nj-depends-on-whom-you-ask/>.

³⁸² See Peter J. Cunningham & Len M. Nichols, *The Effects of Medicaid Reimbursement on the Access to Care of Medicaid Enrollees: A Community Perspective*, 62 MED. CARE RESEARCH & REVIEW 676, 677-78 (2005).

the payment is clearly one factor in ensuring access to beneficiaries. New Jersey's low payment rates for many services are problematic,³⁸³ and not surprisingly, provider participation has suffered.³⁸⁴ While many factors contribute to providers' decisions to participate in Medicaid, payment rates are an important factor, and at a sufficiently low level, continued provision of services to Medicaid recipients is impractical.

Recommendation #3

Medicaid payment rates for primary care and behavioral health services through fee-for-service and Medicaid managed care organizations should be reviewed in order to assure sufficient levels to permit sustainable integrated care.

2. Fiscal agents for Medicaid

In many ways, New Jersey's Medicaid reimbursement for behavioral health is in flux. First, the Comprehensive Waiver approved the "[t]ransform[ation] of the State's behavioral health system for adults by delivering behavioral health through behavioral health administrative service organizations."³⁸⁵ One step has been taken in that regard, as Rutgers University Behavioral Health Care has been contracted to act as "interim managing entity" with respect to substance use disorder care,³⁸⁶ but the shift to an ASO for mental health care has been delayed. In response to a question from the New Jersey Office of Legislative Services on the cause for the delay, DHS responded,

Several issues have impacted the [request for proposal (RFP)] timeline. Factors such as the cost analysis, provider rate setting, and Medicaid Expansion have prompted DHS to reexamine the plan

³⁸³ Kaiser Family Foundation, State Health Facts: Medicaid-to-Medicare Fee Index 2012 (New Jersey's Medicaid payment rates approximately 50% of Medicare payment rates), available at <http://kff.org/medicaid/state-indicator/medicaid-to-medicare-fee-index/>.

³⁸⁴ See Marissa Evans, *New Jersey Doctors Least Likely to Treat Medicaid Patients in 2013*, WASHINGTON HEALTH POLICY WEEK IN REVIEW (Commonwealth Fund, April 15, 2013), available at <http://www.commonwealthfund.org/publications/newsletters/washington-health-policy-in-review/2015/apr/apr-6-2015/new-jersey-doctors-least-likely-to-treat-medicaid-patients-in-2013>.

³⁸⁵ See U.S. Dep't of Health & Human Servcs., NEW JERSEY SECTION 1115 DEMONSTRATION FACT SHEET 1-2, available at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nj/nj-1115-request-fs.pdf>.

³⁸⁶ See *supra* note 321 & accompanying text.

for an ASO. DHS has been analyzing the service implications and the costs of the current RFP to assure that the state is procuring the most cost effective and client centered management system. DHS is weighing the benefits of several different models, including an MBHO or carving the behavioral health services into the Medicaid Managed Care companies.³⁸⁷

A second (and related) major shift in behavioral health reimbursement concerns the plan to replace much of the State-only funding for behavioral health services that are paid on the basis of individual contracts with payment through the Medicaid system, through which more federal funding could presumably be drawn into the State.³⁸⁸ In connection with the shift from contract-based to Medicaid-based reimbursement for behavioral health services, DHS engaged a consulting firm to propose a Medicaid fee-for-service rate schedule to apply to this new payment system. The release of the results of the study has been delayed several times. Recently, DHS, in response to a request for information from the Office of Legislative Services, explained,

Staff have been thoroughly reviewing the underlying calculations and assumptions that built the rates to determine if any changes need to be made. In addition, staff continue to analyze the estimated State and federal budget impacts of the proposed rates, considering projected Medicaid and non-Medicaid utilization. A timetable for a systemwide implementation has not yet been finalized by DHS. This will be determined, in large part, by the results of our planning for a managing entity to oversee the majority of our services. However, DMHAS does intend to finalize the rates and release them to providers in early FY'16. This will allow providers ample time to adjust/change their business model in anticipation of the full system reform.³⁸⁹

It is apparent that DHS is working assiduously on the transition issues. It is impossible at this time to understand precisely the shape of the payment system that will result. It is concerning, however, that the resulting payment system is likely to have many moving parts. Behavioral health service payment responsibilities will likely continue to be divided between Medicaid MCOs (for those behavioral health services covered by their contracts) and the fee-for-service intermediary acting for DHS. Currently, primary care providers report confusion related to the division of payment responsibility between Medicaid MCOs and the State's fee-for-service

³⁸⁷ "Department of Human Services (General)," responses to OLS questions 2015, response to Question 20, available at http://www.nileg.state.nj.us/legislativepub/budget_2016/DHS_response.pdf.

³⁸⁸ See *id.*, Response to Question 21. See also Kitchenman, *supra* note 320.

³⁸⁹ "Department of Human Services (General)," responses to OLS questions 2015, response to Question 21, *supra* note 387.

system when they provide behavioral health services to their primary care patients.³⁹⁰ There is a danger that the use of an administrative service organization more generally for behavioral health services could similarly engender confusion.

Fundamentally, the concern is that divided payment systems for behavioral health care are somewhat clumsy in application, and the reconstruction of a payment system for behavioral health care, if it similarly creates dual payment agents (an administrative services contractor and the Medicaid MCOs), may multiply confusion. Commentators have expressed concern that dividing reimbursement responsibilities among different state agencies can frustrate integration efforts.³⁹¹ In New Jersey, DHS is the primary agency for payment for both physical and behavioral health services. Confusion can arise, however, not only at the agency level, but also at the level of different intermediaries charged by a single agency with managing payments. When gaps in payment systems exist, vulnerable beneficiaries inevitably fall through those gaps. The trend among states moving forward with integrated care is to “consolidate their purchasing, so that a single manage[d] care entity holds responsibility for both behavioral and physical health.”³⁹²

Whether the service is provided for DHS by a managed care entity, an ASO, or some other fiscal agent, consolidation of the functions in one entity serves two important goals. First, a single agent will lessen confusion among providers. If all requests for payment are properly submitted to a single agent, unnecessary delays and denials will be reduced. Second, a single agent cannot avoid payment for a claim by asserting that a particular claim is not its responsibility, but rather is the responsibility of another agent performing a confusingly similar role. Valid claims, therefore, are less likely to be subject to attempts among fiscal agents to shift responsibility. Such simplification is vital to the success of behavioral health integration.

Recommendation #4

DHS, in determining the shape of its fiscal agency model under the Comprehensive Waiver, should consider contracting with a single agent for both physical and behavioral health care claims.

³⁹⁰ See *supra* notes 242-246 & accompanying text.

³⁹¹ See BACHRACH ET AL., *supra* note 317, at 11 (“The historical bifurcation of Medicaid physical and behavioral health services across multiple agencies can result in different – and uncoordinated purchasing strategies for physical and behavioral health services.”).

³⁹² *Id.* at 12.

3. Scope of services

Integrating behavioral and physical health is, as this Report makes clear, a complicated endeavor. People with severe and persistent mental illness but few serious physical health problems, for example, are likely to benefit from the receipt of primary health services in a MHP that has integrated primary care services. Those with mild to moderate needs for both physical and behavioral services, on the other hand, may benefit from the integration of services either in primary care or MHPs.³⁹³ The task of structuring a payment model for care integration can, then, be daunting, and DHS is in different stages of dealing with different aspects of the task.

With respect to people with serious mental illness and substance use disorders, promising initiatives are under way. DHS recently received a grant from SAMSA to pilot a program of integrated care for children with serious emotional disturbance, adults with serious mental illness, and those with serious substance use disorders. The grant will permit DHS, in conjunction with the Department of Children and Families, to implement the New Jersey Certified Community Behavioral Health Clinic (NJ CCBHC) Project. The funding is for a one-year pilot (with the potential for an additional two years of funding) to provide, at two sites, care coordination and services under one roof.³⁹⁴

In addition, DHS is advancing its Behavioral Health Home initiative. Health home initiatives were created by Section 2703 of the Affordable Care Act,³⁹⁵ and permit states to include in their Medicaid programs coordinated care for people with chronic conditions, including a serious and persistent mental health condition.³⁹⁶ DHS piloted Behavioral Health Homes in Bergen and Mercer Counties. These programs provide:

[A]n opportunity to build a person-centered system of care that achieves improved outcomes and better services and value for the NJ Medicaid program. DMHAS has partnered with N.J. Medicaid to expand upon the existing behavioral health case management infrastructure to provide coordinated primary and behavioral health integration.³⁹⁷

Behavioral Health Homes provide “high intensity service targeting those with the most need” and will be expanded to Atlantic, Cape May, and Monmouth Counties beginning January 1, 2016.³⁹⁸

³⁹³ See *supra* Part V(A).

³⁹⁴ Communication with authors, on file with authors.

³⁹⁵ Codified as 42 U.S.C. § 1396w-4.

³⁹⁶ *Id.* § 1396w-4(h)(1)(A)(ii)(III).

³⁹⁷ DHS DMHAS Health Homes, available at <http://www.state.nj.us/humanservices/dmhas/initiatives/integration/hh.html>.

³⁹⁸ *Id.*

Recommendation #5

DHS should continue to pursue initiatives such as Behavioral Health Homes and the NJ CCBHC project to ensure that people with serious and persistent behavioral health needs have access to necessary physical health services in an integrated setting.

Progress on financing integration for people with mild and moderate behavioral health needs is less robust. As is described above, the practices to which providers are subjected in attempting to bill for behavioral health services are confusing and uncertain. Medicaid practices with respect to payment for private practice psychiatrists, physicians, nurses, counselors, and social workers are obscure, and at times unsupported by regulation.³⁹⁹ Little published information exists to guide Medicaid-participating private practice physicians who wish to provide evaluation and management or psychotherapeutic counseling, and private practice social workers and counselors are apparently not permitted to bill Medicaid directly; Medicaid will not reimburse for the services of peer counselors.⁴⁰⁰

Several services that would be of assistance in advancing behavioral health integration are under consideration or in limited use in Medicaid. New Jersey's Comprehensive Waiver application proposed adding screening protocols for behavioral health conditions, and care coordination and case management services to the slate of services reimbursed by Medicaid MCOs,⁴⁰¹ and DMAHS is working to create a form of bundled payment to permit the provision of multiple services on the same day – a vital addition if behavioral health integration is to be advanced.⁴⁰² DMAHS has moved forward with reimbursement of telepsychiatry in many settings, and is working to regularize communication to providers as to the terms and conditions for such services.⁴⁰³ One item of conflict between DMAHS and providers, particularly FQHCs, has been payment for group therapy. DMAHS has committed to working through payment protocols for this important therapy.⁴⁰⁴

An overriding concern regarding the terms and conditions for provider qualification, identification of reimbursable services, and reimbursement limitations on the settings in which

³⁹⁹ See *supra* Part IV(C).

⁴⁰⁰ *Id.*

⁴⁰¹ See *supra* Part IV(D)(1) and (2).

⁴⁰² See *supra* Part IV(D)(3).

⁴⁰³ See *supra* Part IV(D)(4).

⁴⁰⁴ See *supra* Part IV(D)(3).

services may be provided is that these details are in many circumstances only informally provided to those delivering the services. The accretion of rules, exceptions, and limitations causes confusion and clearly inhibits the delivery of services needed for integration. It is also clear that DMAHS is responsible for program oversight, and must enforce limits on reimbursement in order to maintain appropriate spending limits on New Jersey Medicaid. The present transition period, during which the role of Medicaid MCOs and other agents and intermediaries is not yet settled, is a propitious time to seek to add additional clarity and predictability to the professional reimbursement system. It may also be the right time to reexamine the services that are reimbursable in order to ensure that behavioral health integration is not frustrated by adherence to outdated limitations on reimbursement.

Recommendation #6

DHS should use the period of transition to new agents and intermediaries to adjust the terms and conditions of Medicaid participation and payment to facilitate behavioral health integration.

4. Change of Scope applications for FQHCs

Many of the issues inhibiting FQHCs from integrating care into their primary care practices are rooted in licensure concerns, which are addressed elsewhere in this Report.⁴⁰⁵ One important issue remains to be discussed here: whether the addition of behavioral health services in order to permit FQHCs to integrate behavioral and primary care triggers the need for FQHCs to file an application for a Change of Scope of Services. The Shared Services Waiver advanced the goals of behavioral health integration in many regards, but apparently left to DHS, and for another day, the need to carefully consider the threshold for the need to file a Change of Scope application.

The means by which FQHCs are paid by Medicaid differs from the method applied to other providers of services. That method is described briefly elsewhere⁴⁰⁶ in this Report, and that description will not be repeated here. In brief, FQHCs are paid a bundled rate, known as the PPS rate, for the services provided to a patient during one encounter, and they are not paid on a fee-for-service basis for each service provided.⁴⁰⁷ The amount of the PPS rate is computed by

⁴⁰⁵ See *supra* Part III (discussion of New Jersey's licensure rules and practices); Part V(B)(1) (recommendations).

⁴⁰⁶ See *supra* Part IV(B)(2).

⁴⁰⁷ This brief description elides some complexity described above in Part IV(B)(2), and in the sources cited in that Part. For example, in some instances, an FQHC may receive more than one payment for a single patient visit. See *supra* Part IV(B)(2), citing N.J.A.C. 10:66–4.1(a). In addition, because the responsibility for the administration of

beginning with the average cost per encounter during the base years.⁴⁰⁸ That amount is then adjusted yearly by an inflation factor. Otherwise, the rate is adjusted only if the FQHC files a Change of Scope application.⁴⁰⁹ The FQHCs and DHS have a long history of differing understandings on payment issues. One specific ground of disagreement is when an FQHC is required to file a Change of Scope application.

Federal law describes that the PPS rate is to be “adjusted to take into account any increase or decrease in the scope of such services furnished by the [FQHC] during that fiscal year.”⁴¹⁰ CMS has explained that adjustments of the bundled rate must take place when there is a change of the “type, intensity, duration and/or amount of services.” The states have been left some freedom to identify the triggering event requiring the filing of a Change of Scope application, and the means by which a change of scope is to be evaluated. New Jersey regulations relevantly define Change of Scope as “the addition of a new FQHC covered service that is not incorporated in the baseline PPS rate,”⁴¹¹ although the regulation appears to contain language leaving some discretion with DMAHS as to whether or not circumstances evidencing a Change of Scope should give rise to an adjustment in the PPS rate.⁴¹²

Assuming some discretion on the part of DMAHS, there are several policy reasons to exercise discretion not to require the filing of a Change of Scope application when an FQHC provides behavioral health services for mild to moderate behavioral health conditions to facilitate behavioral health integration:

- DMAHS has for many years permitted FQHCs to provide and bill for behavioral health services, so long as those services are captured by HCPCS codes included on a spreadsheet distributed to FQHCs, which codes reflect services appropriate for mild to moderate behavioral health conditions;⁴¹³
- Many Americans receive behavioral health screenings and services for mild to moderate behavioral health symptoms in their primary care provider’s office;⁴¹⁴
- FQHCs service many low-income and vulnerable people for whom FQHCs are the only plausible source of primary care in a setting with continuity of care capacity; and

Medicaid reimbursement is divided between Medicaid MCOs and Medicaid’s fiscal intermediary for behavioral health services, “wrap-around” payments are required to bring an FQHC’s payments to the level required for FQHCs, a process that has engendered some conflict between DHS and the FQHCs. *See* New Jersey Primary Care Ass’n, Inc. v. NJ Department of Human Services, 722 F.3d 527 (3d Cir. 2013) (litigation over the means by which the wrap-around payments were computed and paid).

⁴⁰⁸ The base years for New Jersey’s FQHCs were apparently 1999 and 2000.

⁴⁰⁹ *See supra* Part IV(B)(2).

⁴¹⁰ 42 U.S.C. § 1396a(bb)(3)B).

⁴¹¹ N.J.A.C. § 10:66-1.5(vi)(1)(A).

⁴¹² *See supra* Part IV(B)(2). DHS considered changing the regulation to make adjustment in the PPS rate mandatory, but did not finally adopt the regulation. *Id.*

⁴¹³ *See supra* Part IV(B)(1).

⁴¹⁴ *See Manderscheid & Kathol, supra* note 4, at 61.

- The benefits of integrating behavioral and primary care are significant, both in terms of patient outcomes and long-term cost containment.⁴¹⁵

The addition of FQHC services to encompass care for mild or moderate behavioral health symptoms seems consistent with the clinical consensus that such services are a part of ordinary primary care. The ability of FQHCs to add these services could, as is described in Part IV(B)(2) above, be accomplished by the regulatory definition of a clear trigger for the filing of a Change of Scope application. A twofold trigger could require rate recalculation when, first, behavioral health services were not included in the base year calculation of the FQHC's PPS rate, and, second, such services reach a numerical or percentage threshold calculated as a percentage of the FQHC's Medicaid billing. Other states have some such flexibility in their FQHC payment procedures⁴¹⁶ and employ percentage-based triggers⁴¹⁷ or allow changes in payments to meet public policy needs.⁴¹⁸

The argument for permitting an FQHC to avoid the need for a Change of Scope application is much weaker when the FQHC wishes to add services for people with severe and persistent mental illness. As the description above of the Four Quadrant Model of Behavioral Health Integration suggests, integrated services for people with serious behavioral health symptoms are best provided and coordinated not in a primary care setting, but in a MHP.⁴¹⁹ An FQHC adding such services, then, should reasonably be required to file a Change of Scope application.

Recommendation #7

FQHCs should be permitted to maintain or add behavioral health services to screen and provide services for mild to moderate behavioral health conditions without filing a Change of Scope application; the addition of services for severe and persistent behavioral health conditions should, however, trigger such a requirement.

⁴¹⁵ See *supra* Part II(B) and (C).

⁴¹⁶ See Indiana FQHC/RHC Change in the Scope of Service Guidelines, Part A: Definition of a Change in the Scope of Service (May, 2009), available at <http://in.mslc.com/uploadedFiles/FQHC-RHC%20Change%20in%20Scope%20of%20Service%20Guidelines%20and%20Form.pdf>.

⁴¹⁷ *Id.*, Part B(1): Change in Scope of Service Adjustment Criteria.

⁴¹⁸ The rate may be changed, for example, if "A Provider . . . can demonstrate that access to service delivery is threatened." 114.3 Mass. Code Reg. 4.05.

⁴¹⁹ See *supra* Part V(A).

D. Transparency and Consistency

The previous two Subparts address aspects of New Jersey's licensure and payment systems that inhibit the growth of behavioral health integration. The clinical consensus in favor of combining behavioral and primary care services is strong; augmenting primary care with behavioral health services for mild or moderate mental health or substance abuse treatment, and providing primary medical care in programs treating severe and persistent mental illness can both improve outcomes and save costs over time. We have recommended some changes in both facilities licensure and payment policy. We end this Report with a recommendation that is essential to realizing the gains to be achieved by regulatory facilitation of behavioral health integration. That recommendation is that the agencies speak clearly, publicly, and consistently as to the regulatory requirements for behavioral health integration.

In the course of discussing behavioral health integration, we were struck by the part misconceptions and confusion played in discouraging both MHPs and FQHCs from pursuing integration plans. The confusion had many causes. We believe the three biggest causes were (1) MHPs and FQHCs misunderstanding what the regulatory structure required in terms both of payment and licensure; (2) conflicting and incorrect information provided by agency representatives to program leaders; and (3) agency adherence to interpretations of regulations not clearly set out in the law.

The first two – misperceptions on the part of the regulated community and misinformation provided by agency personnel – are intertwined. We did not have the luxury of tracking down each instance of miscommunication and confusion to find its root cause in either a lack of understanding by the provider or the delivery of misinformation by agency personnel. We believe that there is plenty of both out there on the topic of behavioral health integration. We heard similar stories from program leaders that they had been informed that licensure was impossible when the standards articulated by agency leaders in their meetings with us suggested the opposite. These stories were too common, and too similar, for us not to tentatively conclude that misinformation was sometimes delivered by DHS and/or DOH personnel on the subject of behavioral health integration.

There are three steps that can cure both the problem of free-floating confusion on the part of the regulated community, and inconsistent/incorrect information delivered by agency personnel. First, DOH and DHS have to reach clarity with respect to their own positions – something we found not to be the case on some important issues. Second, the agencies have to clearly disclose their interpretation of their own regulations in settings and in media that will facilitate the adoption of integrative practices. The settings should be in the trade associations of providers of primary care, mental health, substance use disorder, and hospital services. The media should include FAQs on the agencies' web sites and documents on the web sites providing clear, more detailed guidance for programs seeking to integrate care. Third, DOH and DHS should identify staff with responsibility to promote integration and assist stakeholders as they navigate

the system. The regulated community would know whom to contact with questions about the State's integration policies and processes, which would improve transparency and consistency and minimize the risk that myths will frustrate the State's efforts to support and facilitate integration. These staff also can support interagency consultation and cooperation.

The third cause of confusion – agency adherence to positions not clearly supported by their rules – is related to the first two, but has a substantive component. Over the course of years, regulatory practices have arisen and become entrenched, and tend to be followed without resort to reexamination. One example is the interpretation by DOH of its licensure regulations as forbidding the sharing of clinical space by providers of differently licensed services. The agency explained that although its statutes and regulations do not expressly establish this prohibition, DOH interprets references in the ACF regulations to “a facility” to require licensure of a separate, distinct facility that may not share space.⁴²⁰ The rationale for this interpretation may have been plausible at the time it was first developed – the regulatory language does refer to “distinct” parts of facilities. That interpretation seems to have been an over-reading of the regulatory language, but certainly now seems inconsistent with best practices in the delivery of care, as DOH implicitly recognized in the Shared Space Waiver. It is time to reexamine this and other archaic interpretations; if the agency believes it can reexamine the meaning of a regulation to square with modern practice, that should be done. If not, the agency should amend the regulation to serve the interests of consumers and the public.

It is our strong recommendation that DOH and DHS engage in clear disclosure of their regulatory policies with respect to behavioral health integration. If regulations need to be modified or clarified in advance of a full realization of such public explanation, those changes should be made. Most importantly, the agencies should be transparent with regard to their policies, permitting trade organizations, providers, and indeed the agencies' own personnel to have access to full and clear explanations for the requirements for licensure and payment for integrated services.

⁴²⁰ See N.J.A.C. § 8:43A-1.3 (defining an ambulatory care facility as “a health care facility or a distinct part of a health care facility”) (emphasis added); see also American Institute of Architects, *Guidelines for Design and Construction of Health Care Facilities*, 2010 edition, Part 3 Ambulatory Care Facilities, § 3.1 (incorporated by reference in N.J.A.C. §§ 8:43A-1.3, 19.1(a) and describing outpatient facilities as “an outpatient unit in a hospital, a freestanding facility, or an outpatient facility in a multiuse building containing an ambulatory health care facility as defined in the NFPA 101: *Life Safety Code* occupancy chapters”), available at <http://figguidelines.org/digitalcopy.php> (last accessed June 11, 2015). DOH has explained that the intent of the Shared Space Waiver is to waive the provision in N.J.A.C. § 8:43A-2.3(b) that limits a facility licensed by DOH to “provide only those services for which it is licensed or authorized to provide by the Department.”

Recommendation #8

The Departments of Human Services and Health should identify staff with responsibility for integration efforts and provide full and public disclosure of their regulatory policies for the benefit of providers and regulatory personnel in the form of:

- **FAQs and more complete descriptions of regulatory policy on integration on agency web sites**
- **Public outreach to mental health programs, substance use disorder programs, FQHCs and other primary care providers, hospitals, and their trade organizations with full descriptions of agency policy**

VI. Conclusion

This Report was undertaken with the goal of facilitating a modest rethinking of New Jersey's licensure and payment requirements impeding the integration of behavioral and primary care. As we proceeded with this project, it became clear that there were several issues we could evaluate and as to which we could make what we hope are helpful recommendations.

We believe that the analysis contained in this Report will assist the Departments, service providers, and others dedicated to advancing responsible integration of behavioral health and primary care services. We have clearly left many details unaddressed, but progress toward the goal is important and should not await resolution of every issue.

Appendix A: Individuals Consulted and Interviewed for This Report⁴²¹

Melissa Agresti, Continuum Health Alliance

Dr. Kemi Alli, Henry J. Austin Health Care Center

Gene Azoia, New Jersey Department of Human Services

Dr. Lynda Bascelli, Project H.O.P.E.

Acting Commissioner Cathleen Bennett, New Jersey Department of Health

Theresa Berger, Ocean Health Initiatives

Dr. Arturo Brito, New Jersey Department of Health

Jeff Brown, New Jersey Health Care Quality Institute

Mark K. Bryant, CAMcare Health Corporation

John Calabria, New Jersey Department of Health

Nancy Capello, Rowan University School of Osteopathic Medicine

Ruth Charbonneau, New Jersey Department of Health

Kelly G. Chua, New Jersey Department of Human Services

Dr. Lynn Clemow, Rutgers Robert Wood Johnson Medical School

Brian Colangelo, Project H.O.P.E.

Acting Commissioner Elizabeth Connolly, New Jersey Department of Human Services

Dr. Herbert C. Conaway, St. Francis Medical Center

William Conroy, New Jersey Department of Health

Dr. Lesly D'Ambola, St. Luke's Catholic Medical Services

Patricia DeShields, Project H.O.P.E.

Jeanne DeVitto, New Jersey Department of Human Services

Vincent DiGiacomo, New Jersey Department of Human Services

Susan J. Dougherty, New Jersey Department of Health

⁴²¹ All affiliations reflect status at the time of interviews. Several interviewees have changed affiliations in the time since being interviewed.

James Edwards, CompleteCare Health Network

Ron Gordon, New Jersey Association of Mental Health and Addiction Agencies

Valerie Harr, New Jersey Department of Human Services

Deborah Hartel, St. Joseph's Regional Medical Center

Joe Hicks, Barnabas Health Behavioral Health Center

Jillian Hudspeth, New Jersey Primary Care Association

Marsha Johnson, Cooper Advanced Care Center, Cooper University Health Care

Barbara Johnston, Mental Health Association in New Jersey

Michael Keevey, New Jersey Department of Human Services

Roxanne Kennedy, New Jersey Department of Human Services

Lynn A. Kovich, former Assistant Commissioner, New Jersey Department of Human Services;
Technical Assistance Collaborative

Dennis Lafer, Consultant, Mental Health Association in New Jersey

Dr. Thomas Lind, New Jersey Department of Human Services

Sunil Marwaha, Adult Health Institute, Cooper University Health Care

Joseph Masciandaro, CarePlus New Jersey

Susan McGinley, Continuum Health Alliance

Valerie Mielke, New Jersey Department of Human Services

Michele Miller, Rutgers University Behavioral Health Care

Richard Mingoia, Youth Consultation Service

Dr. Theresa Miskimen, Rutgers University Behavioral Health Care

Melanie Mitchell, Ocean Health Initiatives

John Monahan, Greater Trenton Behavioral HealthCare

Shauna Moses, New Jersey Association of Mental Health and Addiction Agencies

Commissioner Mary E. O'Dowd, New Jersey Department of Health

Harry Postel, Catholic Charities, Diocese of Trenton

Gloria M Rodriguez, New Jersey Department of Health

Rosemarie Rosati, Rutgers University Behavioral Health Care
Shabnam Salih, Camden Coalition of Healthcare Providers
Yaakov Schwartz, Center for Health Education, Medicine, & Dentistry (CHEMED)
Jeffrey Steenson, Rowan University School of Osteopathic Medicine
Kathleen Stillo, Cooper Advanced Care Center, Cooper University Health Care
Gerald Suozzo, New Jersey Department of Human Services
Steven E. Tunney, New Jersey Department of Human Services
Eva Turbiner, Zufall Health Center
Angelo Vacirca, Henry J. Austin Health Care Center
Dr. Sara Wallach, St. Francis Medical Center
Anthony S. Welch, New Jersey Department of Health
Debra Wentz, New Jersey Association of Mental Health and Addiction Agencies
Chedva Werblowsky, Center for Health Education, Medicine, & Dentistry (CHEMED)
Lauri Woodward, New Jersey Department of Human Services
Kelly Workman, Rowan University School of Osteopathic Medicine

Appendix B: Department of Health Shared Space Waiver, October 19, 2015



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DEPARTMENT OF HEALTH
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www.nj.gov/health

CHRIS CHRISTIE
Governor

KIM GUADAGNO
Lt. Governor

CATHLEEN D. BENNETT
Acting Commissioner

To: FQHCs and Other Department of Health Licensed Primary Care Facilities, Primary Care Association

From:  John A. Calabria, Director
Division of Certificate of Need and Licensing

Date: October 19, 2015

Re: Waiver to Permit Sharing of Clinical Space

The Department of Health (Department) generally does not permit the sharing of clinical space. However, in recent years, the Department has granted individual waivers, pursuant to N.J.A.C. 8:43A-2.9, to a number of facilities to permit the sharing of clinical space in certain circumstances. In order to promote the integration of primary care and behavioral health services, the Department hereby grants a global waiver to permit the sharing of clinical space to all Department-licensed facilities providing medical primary care services that also wish to offer behavioral health services in accordance with the provisions as listed below. This global waiver to permit the sharing of clinical space will relieve the Department-licensed facility from the requirement of having to obtain additional space in order to have medical and behavioral services provided in separate clinical areas.

1. The Department-licensed facility shall obtain the appropriate license(s) from the Department of Human Services (DHS) to permit it to offer behavioral health services. Separate licenses are currently required for mental health services and substance abuse services.

2. At the time the Department-licensed facility submits a DHS licensing application to DHS, the applicant shall include with the application: (a) a copy of the Change in Scope of Service application; and (b) an attestation in writing stating that (i) the entity that is applying for the DHS license(s) is the exact same legal entity that holds the Department license and that entity shall be fully accountable and responsible for all services provided in its facility, and (ii) the applicant is not planning to make any changes to the physical plant or, if changes are planned, it has applied for and received approval from the Department of Health. A copy of the Department's approval letter notifying the facility that they can proceed with construction of any physical plant changes, or a letter from the Department stating that Departmental approval is not required, must accompany the DHS application for licensure.

Waiver to Permit Sharing of Clinical Space
Page 2

3. The Department-licensed facility must continue to meet all of the Department's licensing requirements set forth in N.J.A.C. 8:43A and 43E.

4. It is the responsibility of the Department-licensed facility to forward to the Department a copy of any license issued to it by DHS.

5. Department and DHS staff will work together to ensure appropriate and necessary substantial compliance with their respective licensing requirements. The applicable licensing department shall take the lead in addressing any patient/family complaints or licensing violations pertaining to the program it licenses at the facility.

It remains the responsibility of each facility proposing to take advantage of this waiver program to understand and comply with any Medicaid requirements including, but not limited to, Change in Scope applications.

Should you have any questions regarding this memorandum, please call me at 609-292-8773 or email me at John.Calabria@doh.state.nj.us. Should you have questions regarding DHS licensing requirements or the scope of services permitted under a DHS license, you may call Jean DeVitto at 609-292-1550 or email Ms. DeVitto at Jean.DeVitto@dhs.state.nj.us.

c: Susan Dougherty, Assistant Commissioner, Division of Certificate of Need & Licensing, DOH
Jean DeVitto, Chief, Office of Licensing, DHS

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