Behavioral Health Carve-In and HARP

May 18, 2016

4:00 p.m. – 7:30 p.m.

Today's Agenda

4:00 – 4:15	**Welcome**	**Robert Holtz**
4:15 – 4:30	Contracting	Misty Lunde
4:30 – 4:45	Provider Services	Chena Backer
4:45 – 5:00	BH Access Center	John Arcuri
5:00 – 5:30	Dinner	
5:30 – 6:15	Select Plan/HARP Overview	Sheila Nelson
6:15 – 6:45	Case Management	Kelly Lauletta Jane Wilson
6:45 – 7:15	Utilization Management	John Arcuri Debbie Manginelli
7:15 – 7:30	Questions and Answers	

Welcome

Robert Holtz

Vice President, Behavioral Health

Contracting and Credentialing

Misty Lunde, QIPs and ARSs Program Manager

Lisa Ricci, Credentialing Team Leader

Contracting and Credentialing

- Contracting rules outlined in state policy
- Rules apply to:
  - Network sufficiency
  - Payments
  - Credentialing

http://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/related_links/docs/bh_policy_guidance_10-1-15.pdf

ANDREW M. CUOMO, Governor — HOWARD A. ZUCKER, M.D., J.D., Commissioner, DOH — ANN MARIE T. SULLIVAN, M.D., Commissioner, OMH — ARLENE GONZALEZ-SANCHEZ, M.S., L.M.S.W., Commissioner, OASAS

Transition of Behavioral Health Benefit into Medicaid Managed Care and Health and Recovery Program Implementation

Released October 2015

Contracting and Credentialing

- OMH and OASAS minimum network standards are outlined below.

Service	Urban Counties	Rural Counties[21]
OASAS		
Opioid Treatment Programs	All per county and for NYC – all in the City	All per region
Inpatient Treatment	2 per county	2 per region
Detoxification (including Inpatient Hospital Detoxification, Inpatient Medically Supervised Detoxification, and Medically Supervised Outpatient Withdrawal)	2 per county	2 per region
Outpatient Clinic	50% of clinics or a minimum of two clinics per county, whichever is greater.[22]	50% of clinics or a minimum of two clinics per county, whichever is greater.[22]
Residential Addiction Services	2 per county	2 per region
Buprenorphine prescribers	All authorized prescribers serving Medicaid patients	All authorized prescribers serving Medicaid patients
OMH/OASAS		
Behavioral Health Home and Community Based Services[24] (HARPs Only)	Minimum of two providers of each HCB service per region.	Minimum of two providers of each HCB service per region.

Service	Urban Counties	Rural Counties[21]
OMH		
Outpatient Clinic	50% of clinics or a minimum of two clinics per county, whichever is greater.[22]	50% of clinics or a minimum of two clinics per county, whichever is greater.[22]
State Operated Outpatient Programs	All in county	All in region
PROS, IPRT or Continuing Day Treatment[23]	50% of all such providers or two providers per county, whichever is greater	50% of all such providers or two providers per county, whichever is greater
ACT	2 per county	2 per region
Partial Hospitalization	2 per county	2 per region
Inpatient Psychiatric Services	2 per county	2 per region
Comprehensive Psychiatric Emergency Program & 9.39 ERs	2 per county	2 per region
Crisis Intervention	in accordance with the State issued "Guidelines for Behavioral Health Network Adequacy See 3.6.G	in accordance with the State issued "Guidelines for Behavioral Health Network Adequacy See 3.6.G
Community Mental Health Services	TBD	TBD

Contracting and Credentialing

l) The Contractor shall include the following contract provisions in Provider Agreements with providers operated, licensed or certified by OMH or OASAS **with five or more active Plan members in treatment** required pursuant to Section 21.19(a)(ii) of this agreement:

i) The Provider Agreement shall be for a **minimum term of 24 months** from the Behavioral Health Inclusion Date in each geographic service area, unless otherwise prohibited by the terms of this Agreement; and

ii) The Contractor shall **pay at least the applicable Medicaid fee-for-service rate for a minimum of 24 months** effective on the date of the Behavioral Health Benefit Inclusion in each geographic Service Area.

Contracting and Credentialing

…upon the date of the Behavioral Health Benefit Inclusion in a geographic service area, the Contractor **must establish contracts with any providers** operated, licensed or certified by OMH or OASAS **with five or more active Plan members in treatment**, as determined by OMH and OASAS. **The Contractor is not required to contract with such providers if they are unwilling to accept the Medicaid fee-for-service rate.**

Contracting and Credentialing

- CDPHP has issued contracts, amendments, or otherwise contacted all providers the state has designated as “must have.”
- OASAS Providers
  - Some contracts already in place, but we needed to add state required language for APGs, etc.
- OMH Providers
  - Some new contracts were issued to bring on previously non-par providers.
  - APG language is already in place with existing providers.
  - Need operating certificates to determine licensed services per site.

Contracting and Credentialing

E. Credentialing of OMH Licensed and OASAS Certified Providers

As provided by the Managed Care Contract, when credentialing OMH-licensed, OMH-operated, and OASAS-certified providers, the MCO shall accept OMH and OASAS licenses, operation and certifications in place of, and not in addition to, any MCO credentialing process for individual employees, subcontractors or agents of such providers. The MCO shall collect and accept program integrity related information from these providers, as required in Section 18 of the Managed Care Contract, and shall require that such providers not employ or contract with any employee, subcontractor or agent who has been debarred or suspended by the federal or state government, or otherwise excluded from participation in the Medicare or Medicaid program.

Credentialing consists of two processes:

i. The assurance that individuals providing services possess the qualifications to provide such services.

   The State's licensing or certification of a provider will signify the behavioral health provider staff meet the program credentialing requirements. Accordingly, the MCOs must accept such licensing or certification as sufficient to meet the credentialing requirement.

ii. The assurance that individuals providing services have not been disqualified or de-barred from providing such services under the Medicare/Medicaid programs by federal or state government.

- We are collecting operating certificates and are credentialing providers at the clinic level.
- We must collect the program integrity information. You can give us a copy of your Medicaid application form.

Contracting and Credentialing

- If you are not sure if you have received a contract, amendment, or request for an operating certificate, contact Misty.Lunde@cdphp.com.
- Please ensure you send in the operating certificate to speed along your ability to engage in claims testing!

Provider Services and Provider Relations

Chena Backer
Provider Relations Specialist

What Resources are Available Online?

- Member eligibility
- Benefits
- Claim submission, status, and appeals
- Prior authorization guidelines
- General forms

Provider Account Tools

Providers Secure Site | Log Out | My Account

Welcome

You can easily find what you need in our self-service area.

- Quickly access member information
- Simply review claims and services
- Provider resources designed to help you get the most out of CDPHP

Watch the Provider Welcome Tour to learn more or select any topic to get started.

FIND A MEMBER

VIEW CLAIMS

PROVIDER ACCOUNT

PROVIDER RESOURCES

ACCOUNT TOOLS

> Find a Member

CLAIMS & SERVICES

> View Claims
> View Authorizations
> View Vision Accumulators
> Access Code Auditing Guidelines

ONLINE FORMS

> Provider Review Request
> Update Member PCP

REPORTS

> View Reports

PROVIDER LOOKUP

> Find a Provider
> Find a Facility

Member Information

Member Information:

Member Information

Name:
Current Medical Plan Medicaid (Noncovered En
Member ID:
Birth Date
Relationship:
Address:
County: Saratoga
Phone:
Gender: Male

Claims and Authorizations

View Recent Claims
ıthorizations
Provider Review Request

Subscriber and Eligibility Details

Subscriber (ID):
Group (ID): Medicaid Select Plan /FHP (10011238)

Medical Eligibility History

Benefit Plans	Plan Name	Status	Effective Date	Term Date
Medical Product	Medicaid (Noncovered Emergent)	Eligible	01/01/2016	

Coordination of Benefits (COB)

There is no Coordination of Benefits (COB) for this member

- Search for members using ID number, or name and date of birth
- Effective date of current and previous plan will be listed
- If they are enrolled in a HMO product, their selected PCP will be listed
- If the member has other insurance, this will be listed in the Coordination of Benefits (COB) section
- Option to review more benefits by clicking on the Current Medical Plan name

Benefit Viewer

View Benefits & Accounts - Current Benefit Periods

Member Effective Since: 1/1/2016

Plan Name: Medicaid (Noncovered Emergent)

Group Name: Medicaid Select Plan /FHP

Group Number: (10011238)

- Deductible Accumulator
- Limit Information
- View Vision Accumulators

Benefit Search

Select a Benefit Category... | Select a Benefit...

Medical | Prescription | Dental

Durable Medical Equipment	0%	Emergency Room	$0
Group Size	Individual	Inpatient Member Responsibility	$0
Outpatient Surgery	$0	PCP Member Responsibility	$0
Specialist Member Responsibility	$0		

Deductible Accumulator | Limit Information

There is no Deductible Information found for this plan.

- The benefit viewer will provide an overview of the copays, deductibles, and/ or coinsurance with a patient's plan.
- Will also provide information on their group size (e.g., large, small, or individual).

Benefit Viewer

Benefit Search

Wellness/Alternative | Smoking Cessation

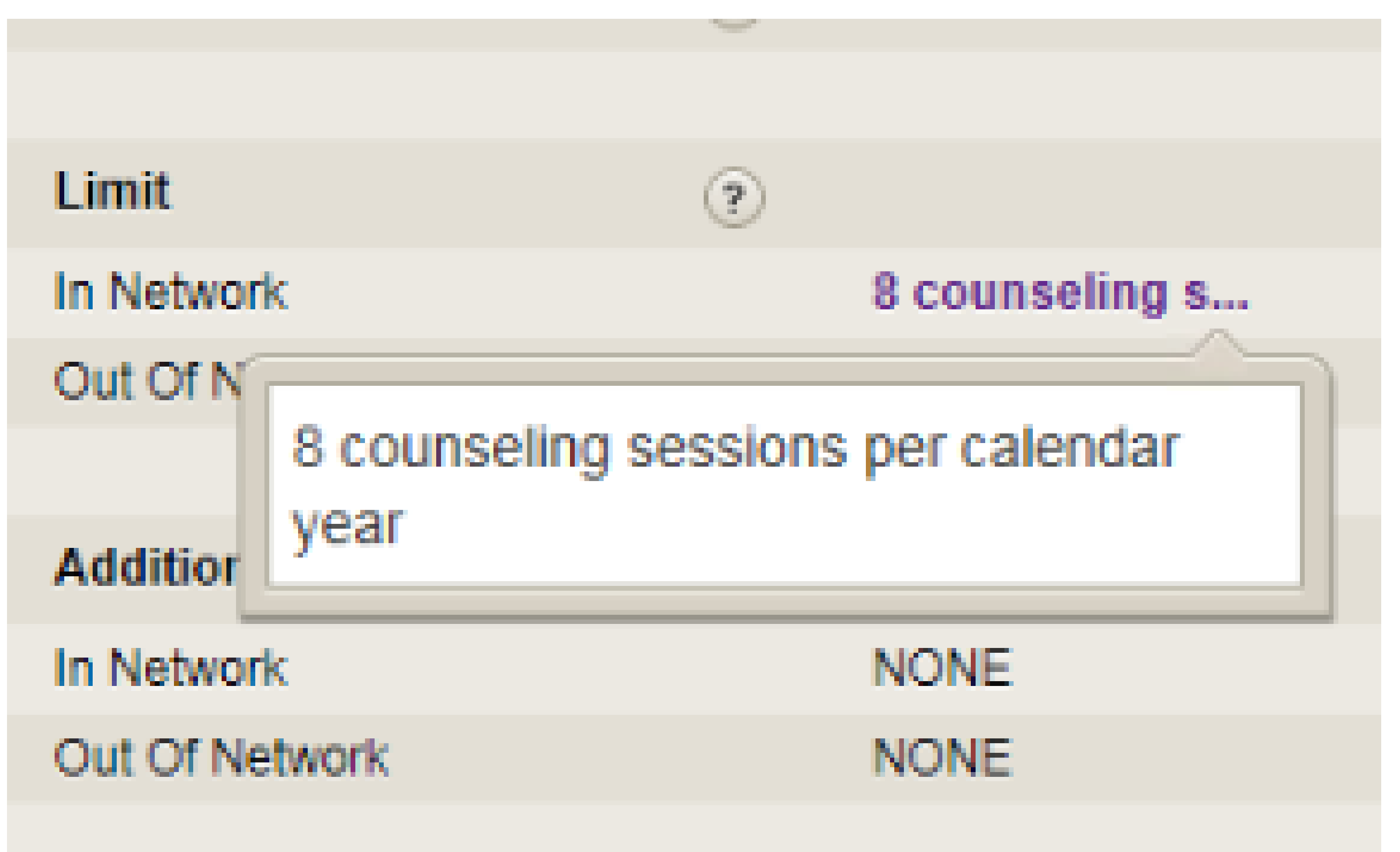
Benefit Detail	Place of Service		
Deductible	**Provider Office**	**Hospital Inpatient**	**Hospital Outpatient**
In Network	Covered In Full	Covered In Full	Covered In Full
Out Of Network	Not Covered	Not Covered	Not Covered
Coinsurance			
In Network	Covered In Full	Covered In Full	Covered In Full
Out Of Network	Not Covered	Not Covered	Not Covered
Copay			
In Network	Covered In Full	Covered In Full	Covered In Full
Out Of Network	Not Covered	Not Covered	Not Covered

- Using the drop down menus will provide the member’s cost share for specific benefits.

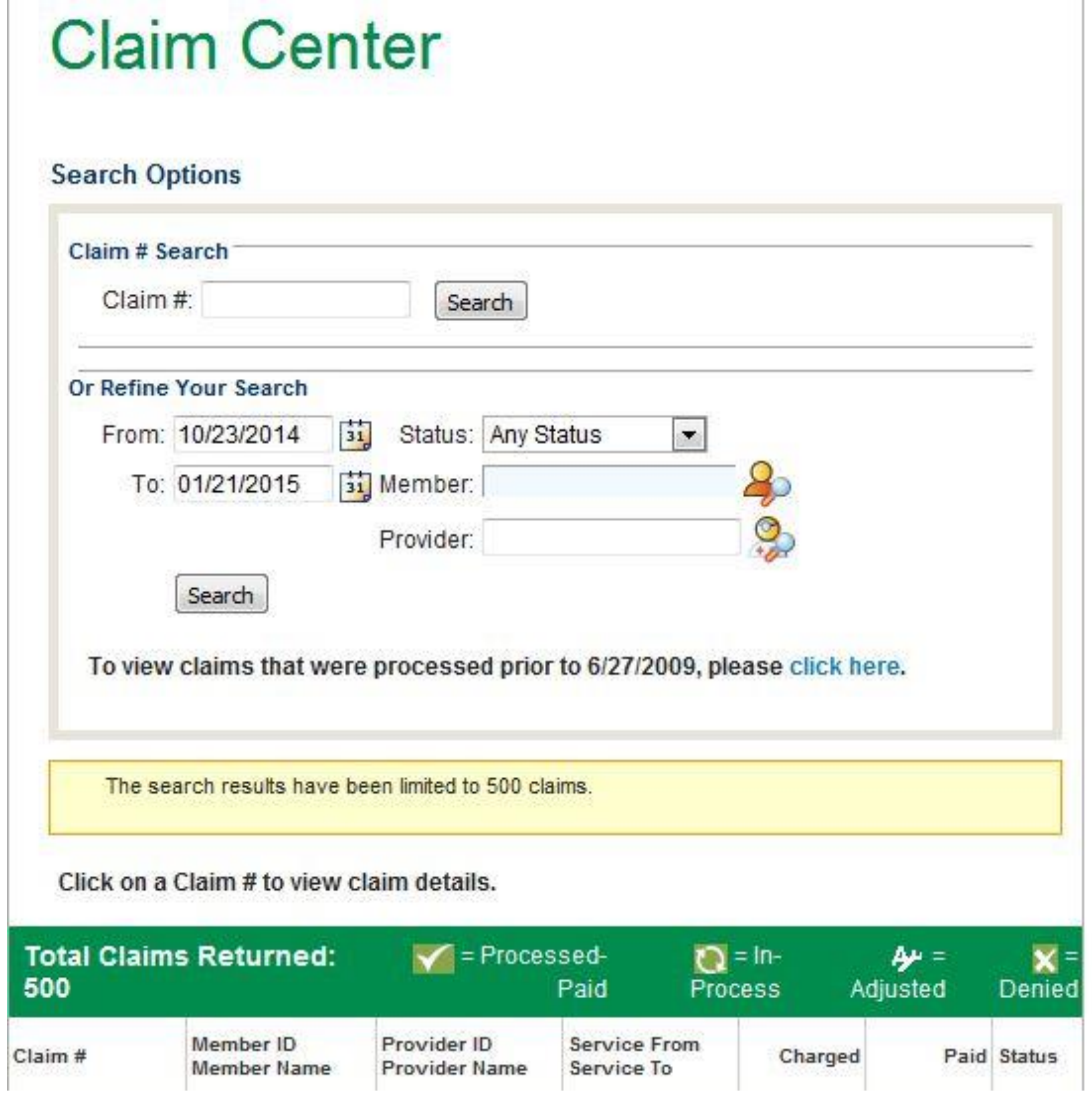
Benefit Viewer

- For some benefits, the limit and additional information fields will provide specific terms to consider when trying to determine the member's benefit.

- Reviewing CDPHP policies may still be required to fully determine prior authorization guidelines.



Claims Center



- You can search your submitted claims using:
  - Claim number
  - Date range
  - Member or Provider ID

Submit a Claim

- CDPHP currently accepts claims through the 837i format or the UB-04 claim form.
- We are working to facilitate an online claim submission solution in time for the 7/1/2016 effective date.
- For those new to the UB-04 format, please reference the information provided by MCTAC: http://mctac.org/page/get-the-right-tools/#goto_BILL
- If you are new to the 837i format, you will need to complete an enrollment form by visiting www.cdphp.com.

Claims

- 835 Electronic Remittance Advice Enrollment Request
- 835 Transaction Companion Guide
- 837 Access Information Request
- 837 Transaction Companion Guide
- Provider Review Form
- Tutorial: How to Complete the Provider Review Form
- Provider Distribution Program Order Form

Claim Detail

- Claims Detail page will provide specific information on any claims you submit to CDPHP.
- Both the diagnosis and procedure codes received by CDPHP will be viewable in this screen.
- If a charge is denied, the Explanation (EX) code and its description will be listed at the line level.

Claims Detail:
Claim #:

GROUP
Medicare Choice - Individual (10011236)

DATE OF BIRTH	GENDER	SUBSCRIBER NAME	COVERED UNDER
			Medicare Choice Plan (C&D)

Claim Summary — Return to results page — Print this page

STATUS	CHARGED	ALLOWED	PLAN PAID	HRA PAID	MEMBER RESP.
Processed-Paid	$59.00	$28.93	$25.17	$0.00	$0.00

Service Dates: From 10/28/2014 to 10/28/2014
Provider:
Diag Code: 5718 Oth Chron Nonalcohlic Livr Disease ; 5939 Unspecified Disorder Kidney&ureter
Authorization #:
Referring Provider:
Paid On: 11/25/2014
Check #:
HRA Check #:
Third Party Paid: $0.00
Status Effective Date: 11/22/2014

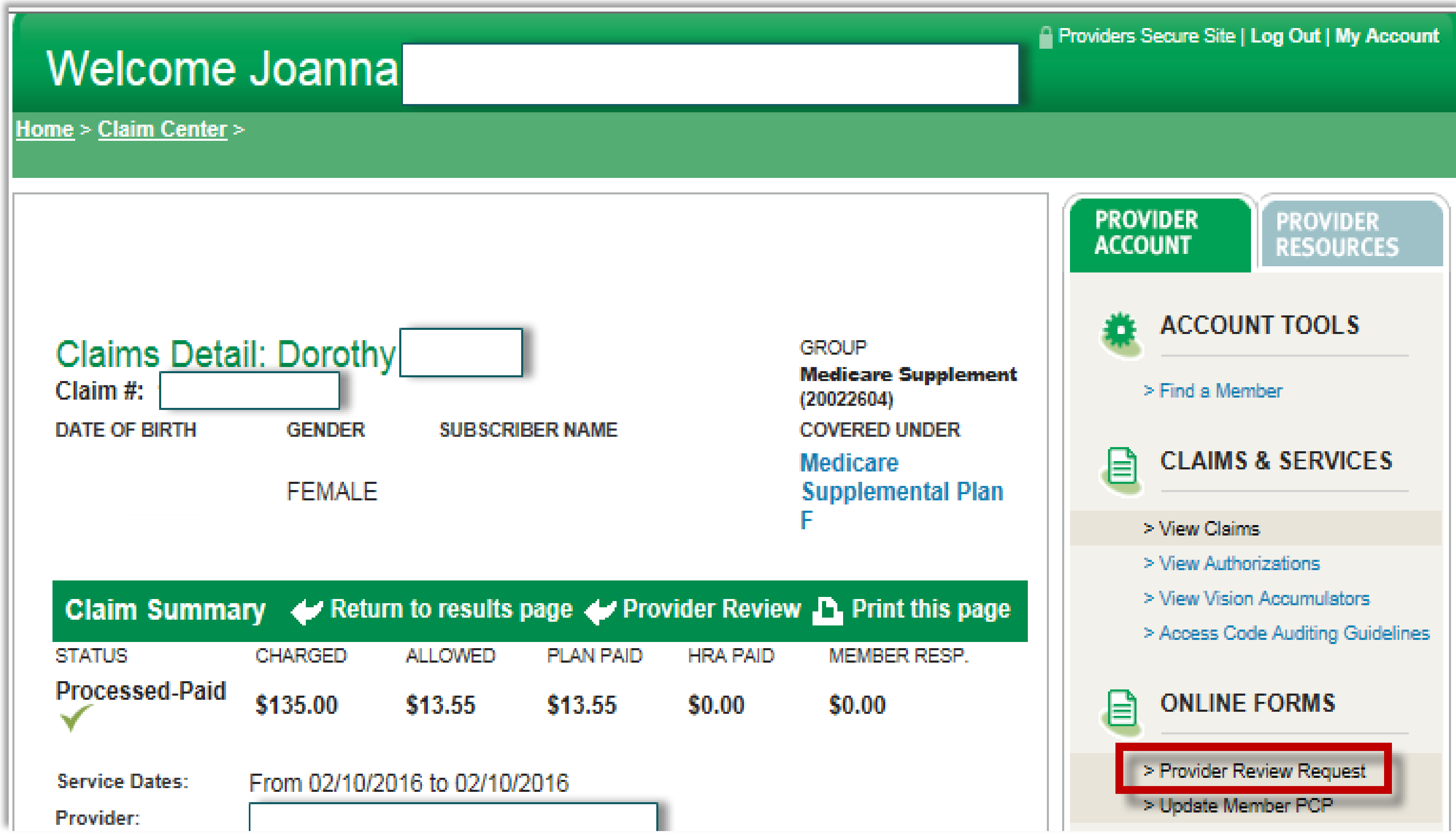
Claim Items — Learn how to read a claim

Line #	Status Processed Date	Charged	Plan Paid	HRA Paid	Ex Code with Explanation
01	PAID 11/25/2014	$59.00 Copay $0.00 Deductible $0.00 Coinsurance $0.00	$25.17 Risk HRA Ded	$0.00 $3.76 $0.00	

Service from 10/28/2014 to 10/28/2014 , Units: 1
***Procedure Code:** 7670526 Ultrasound Of Abdomen*

Totals:	$59.00	$25.17	$0.00
	Copay $0.00 Deductible $0.00 Coinsurance $0.00 Risk $3.76 HRA Ded $0.00		

Claim Appeals



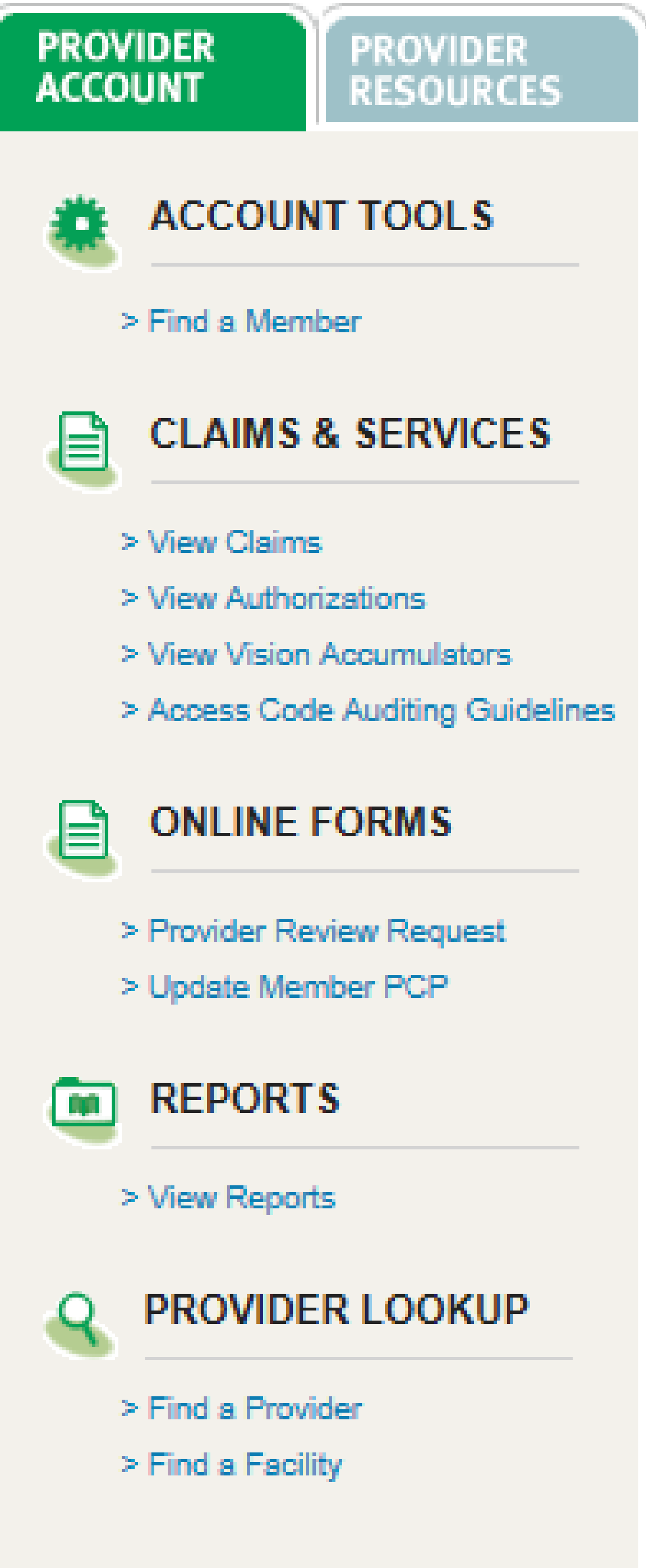
- Appeals can be submitted through traditional means (mail, fax) or using our new online Provider Review Form (PRF).
- Accessing the form through the links in the provider portal will pre-populate the PRF with many of the required fields, reducing the risk of entering inaccurate information and saving your office time.

Claim Payment

- CDPHP sends payment each Tuesday via mail.
- Electronic funds transfer (EFT) is available to all groups.
- CDPHP has partnered with The Council for Affordable Quality Healthcare (CAQH®) to offer this service.
- Enrollment is processed directly through CAQH on their site located at http://www.caqh.org/solutions/enrollhub.

Provider Account Tools

- Other services available in the Provider Account Tools:
  - Authorizations
  - Code auditing guidelines
  - Reports
  - Link to Find-A-Doc to assist member in locating a provider or facility that participates with CDPHP



Provider Resources

CDPHP®

- Our Provider Resources Section provides the supporting documents to verify:
  - ➢Prior authorization requirements
  - ➢Treatment limits
  - ➢HEDIS information

PROVIDER ACCOUNT

PROVIDER RESOURCES

MANUALS & FORMS

Read the facility administration manual, provider office administrative manual, provider forms, and more.

MEDICAL POLICIES

Review current and upcoming medical policies.

QUALITY POLICIES

Discover the details of various Quality Management policies.

Manuals and Forms

Manals and Forms

CDPHP understands your time is valuable and is best used serving your patients. For your convenience, we created a Provider Office Manual as a one-stop source of information about our products, policies, and procedures. We hope you find it useful.

The Provider Forms you need to participate in the CDPHP network can easily be accessed and downloaded to your computer.

Provider Office Administrative Manual

Designed to give you and your staff a comprehensive overview of CDPHP and its current administrative practices, Volume I of the Provider Office Administrative Manual assists you in the day-to-day delivery of CDPHP medical benefits.

To make it easier for your office, we have compiled all CDPHP policies into Volume II of the Provider Office Administrative Manual.

- The Provider Office Administrative Manual (POAM) contains an overview of the most important CDPHP information for offices.
- Sections 3 and 18 of the POAM provide information on Government Programs and Behavioral Health.
- Volume II contains a full index of all of our policies and prior authorization guidelines.

Prior Authorization Guidelines

While there is one resource coordination prior authorization guideline, there are two for pharmacy.

Medicare has a specific Pharmacy Prior Authorization Guideline.

Volume 2 - Policies

Section 1 - Resource Coordination and Medical Policies
Section 2 - Pharmacy Policies
Section 3 - Credentialing Policies
Section 4 - Quality Policies
Section 5 - Prior Authorization Policies

CDPHP Medicare Choices Pharmacy Prior Authorization Guidelines (effective 8-1-14)

Pharmacy Prior Authorization Guideline (effective 12-10-14)

Resource Coordination Prior Authorization Guideline 11-1-14

Medicaid/HARP plan formulary and updates

Forms and tools

Find-A-Doc, the CDPHP online provider directory

Additional online resources available at www.cdphp.com/providers

Keep in Touch

- Annually, we will request a roster of each clinic's practitioners. Providers have an obligation to monitor their information on Find-A-Doc and promptly notify CDPHP of any changes.

- All updates to tax ID and physical or remit address changes must be submitted in writing.

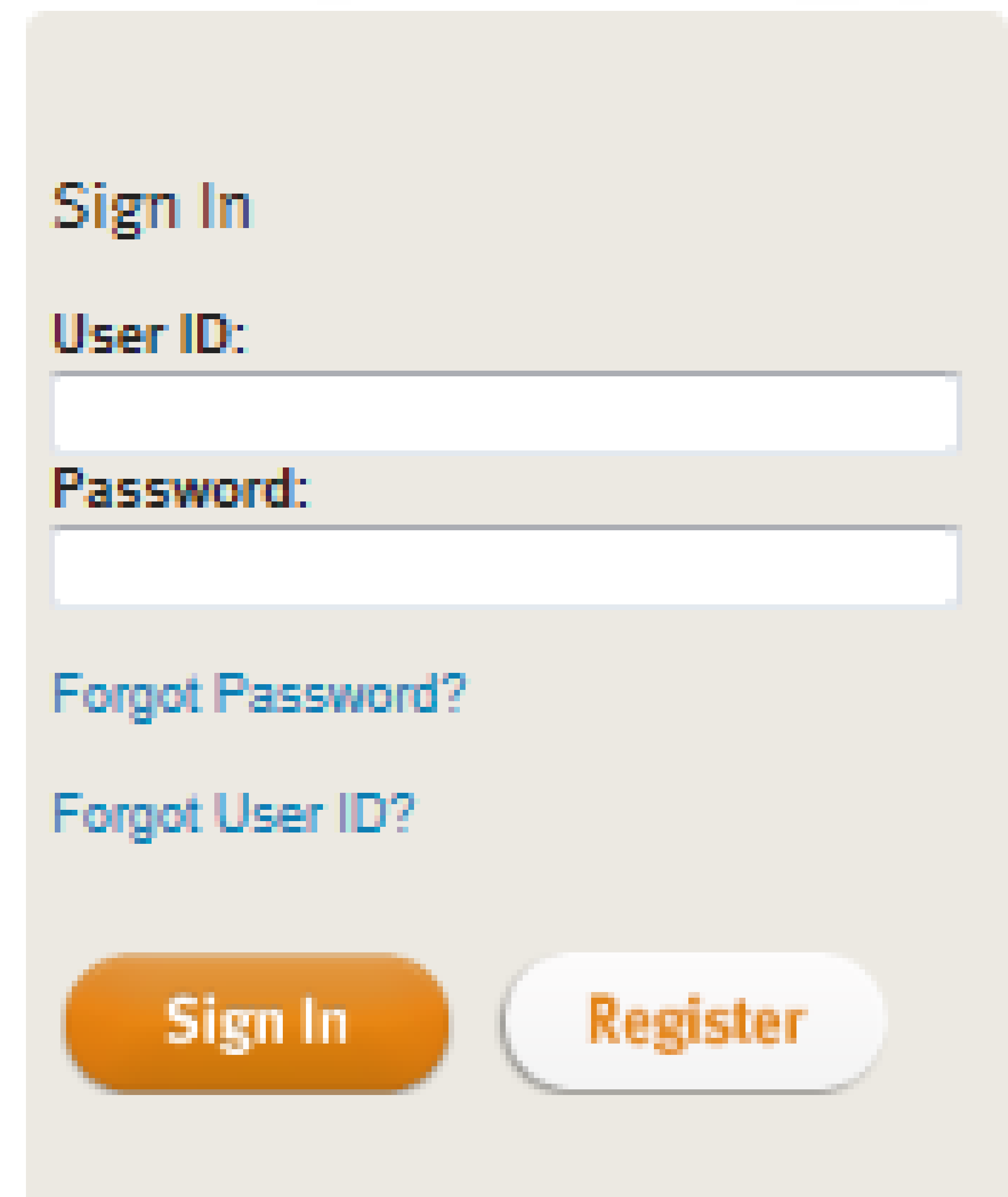
- These changes often require a W-9 to accompany the request.

- These requests can be mailed or faxed to provider reimbursement at (518) 641-3209.

- Using our Practitioner Information Change Form will ensure you include everything that is needed to facilitate the updates.

How Do I Register?

- Register online from any home page on our site.
- Access will be granted within five business days.



Contacting CDPHP

- Provider Services Call Center
  - (518) 641-3500 or 1-800-926-7526, Monday – Friday, 7:30 am to 5 pm
  - Assist with general questions such as address updates, provider portal registration, signing up for 835s or EFT, and how to navigate the provider portal or www.cdphp.com.

- Provider Relations
  - (518) 641-3890 or ProviderRelations@cdphp.com
  - Assist with general questions regarding registration for testing claims, issues regarding 835s, EFT, or other escalated issues that are unable to be handled through the provider services call center or the Behavioral Health Access Unit.

Behavioral Health Access Center

John Arcuri, LMSW

Manager, Behavioral Health

Medicaid

Behavioral Health Clinical Intake Specialist

- The intake unit serves as the front line for member and provider inquiries
  - Staffed by behavioral health professionals
  - Supervised by a licensed social worker
- Intake Specialists:
  - Verify member eligibility
  - Answer benefit inquires for all lines of business
  - Ask scripted screening questions that include relevant clinical and social information
  - Provide routine referrals

Behavioral Health Clinical Intake Specialist - Continued

- The unit reviews special requests for outpatient level of care (OON, test requests, certain non-covered services).
- The unit reviews prior authorization and concurrent review requests for all new ambulatory behavioral health services that have authorization requirements.
  - This will include required review of the plan of care for those HARP members eligible for Home and Community Based Services.

Behavioral Health Clinical Intake Specialist - Continued

- The unit provides assessment and triage
  - Assists with referrals for mental health and substance use disorder
  - Directly provides member triage and referral for BH services, including treatment for substance use disorders, 24 hours per day/ seven days per week
- Conducts telephonic assessments (with triage to case management when necessary)
  - Social workers and registered nurses assist with clinical determinations, urgent and emergent care, crisis calls, and referrals to facilities

Contact Lifeline

- CDPHP contracts with Capital Counseling, which provides crisis assessment and triage after normal business hours, weekends, and holidays
- Contact Lifeline is staffed by licensed mental health clinicians
- Members can access Contact Lifeline services by:
  - Calling the Behavioral Health Access Center at 1-888-320-9584 and choosing option #1
  - Calling Contact Lifeline directly at 1-855-293-0785

Important Numbers

CDPHP Department	Contact Number
Behavioral Health Access Center	1-888-320-9584 or 518-641-3600
Behavioral Health Fax	518-641-3601
Contact Lifeline	1-855-293-0785
Single Source Referral Line	1-866-629-9387 or 518-641-3466
Provider Services	1-800-926-7526 or 518-641-3500
Member Services	518-641-3800 or 1-800-388-2994
Caremark	1-888-292-6330

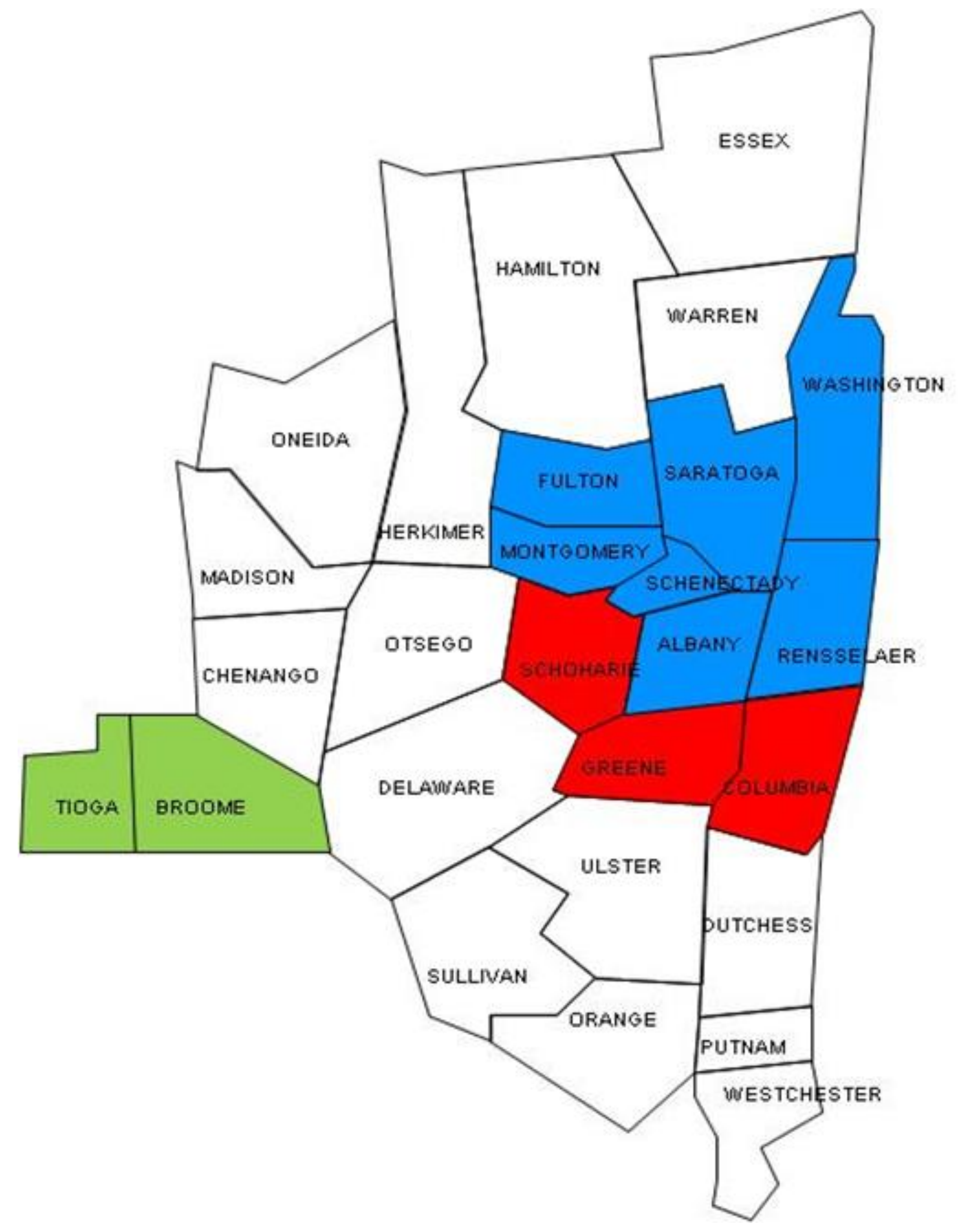
CDPHP Medicaid Products Select Plan and HARP

Sheila Nelson

Vice President, State Programs

Medicaid Products Overview

- The CDPHP mainstream product is called **Select Plan.**
- We have elected not to use a product name for our HARP product.
- We currently offer Select Plan and HARP in 12 counties.
- Eighty-five percent of total Medicaid enrollment is in the northeast region, with 75 percent of this regional total centered in the four-county Capital Region of Albany, Schenectady, Rensselaer, and Saratoga.



Medicaid Products Overview

	CDPHP Share of Medicaid Enrollment			
	Albany	**Rensselaer**	**Saratoga**	**Schenectady**
TANF	56%	60%	54%	40%
SSI	70%	73%	72%	56%
Total for County	63%	67%	59%	46%

- CDPHP serves 59% of the managed Medicaid population in the Capital Region.
- CDPHP serves a significant majority of SSI recipients (67%) in the Capital Region.

Medicaid Products Overview

Early view of HARP enrollment - May 2016 roster

Rating Region		County	TANF Adult	SSI	Total
Capital		Albany	34	252	286
Finger Lakes		Broome		5	5
Central		Columbia	5	38	43
Capital		Fulton	1	18	19
Central		Greene	8	50	58
Capital		Montgomery	3	30	33
Capital		Rensselaer	14	194	208
Capital		Saratoga	16	72	88
Capital		Shenectady	30	199	229
Central		Schoharie	7	29	36
Finger Lakes		Tioga		11	11
Capital		Washington	1	16	17
Service Area Wide			**119**	**914**	**1,033**
			12%	88%	100%
Capital		85.2%	99	781	880
Central		13.3%	20	117	137
Finger Lakes		1.5%	0	16	16
		100.0%	119	914	1033

- Only roster based enrollment (H codes) insight so far. Exchange enrollment still in the works.
- The bulk of enrollment (88%) is in the SSI eligibility group. 12% are TANF Adults.
- 85.2% are in the Capital Region.
- Low enrollment in the Finger Lakes (Broome and Tioga) – 16 people (all SSI).

Medicaid Products Overview

eMedNY ePACES

Help | Log Out

CAPITAL DISTRICT PHYS HLTH PL - 01183013

Claims
- New Claim
- Find Claims
- Real Time Responses
- Build Claim Batch
- Submit Claim Batches
- Status Inquiry
- Status Responses

Eligibility
- Request
- Responses

PA/DVS
- Initial Request
- Revise/Cancel Request
- Responses
- Image Upload
- PA Roster
- PA Roster Downloads

Support Files
- Provider
- Other Payer
- Submitter

Department of Health

Eligibility Response Details

Client Information:

Client ID:
Gender:
Date of Birth:
Anniversary Date:
Recertification:
County: Schenectady
Date of Service: 5/11/2016

Client Name:
SSN:
Address 1:
Address 2:
City, State Zip:
Office:
Plan Date: 5/1/2016

Medicaid Eligibility Information:

ELIGIBLE PCP

Co-pay Remaining: $0.00

Covered Services

Code	Description
MH	Mental Health

Medicaid Managed Care:

Plan name: CAPITAL DISTRICT PHYS HLTH PL
Address: 500 PATROON CREEK BL
DIRECTOR GOVERMENT P
ALBANY, NY 122065006
Phone: (518) 641-3500
Plan Code: CG

Medicaid Exceptions:

Exception Code
H9
35

- ePACES screen view
- H9 – HARP eligible – pending enrollment
- This person has been determined to be categorically eligible for a HARP. They will be given the option of moving to a HARP (where they will be given code H1, with the potential for H2 or H3 based on the assessment results)

Medicaid Products Overview

- Starting **July 1, 2016** (for adults only)
  - Select Plan gets new benefits and HARP begins enrollment.
  - Select Plan and HARP will have the same physical health benefits with one exception.
    - HARP members do not have a long-term nursing home benefit.
  - Select Plan and HARP will have the same behavioral health benefits.

- Starting **October 1, 2016** (for adults only)
  - HARP members ONLY are eligible for additional Behavioral Health Home and Community Based Services (BH HCBS).
  - Mainstream Medicaid members cannot access BH HCBS.

Medicaid Products Overview

Table of Contents—Government Programs

A. Medicaid 3-3
- Referrals 3-3
- Transitional Care—Enrollee New to Plan 3-3
- Restricted Recipient Program 3-4
- Mandatory Program 3-4
- Medicaid Covered Services 3-5
- Transportation 3-11
- Gender Reassignment Surgey 3-11
- Residential Health Care Facility Services (Nursing Home) 3-12
- Personal Care Services 3-12
- Consumer Directed Personal Care Services 3-13
- Adult Day Health Care and AIDS Adult Day Health Care 3-13
- Personal Emergency Response System 3-14
- Home and Community Based Service (HCBS)—HARP Only 3-15
- Benefits Provided Through Medicaid Fee-For-Service 3-15
- Benefits Not Covered by CDPHP or Medicaid 3-15
- Claims 3-15
- CDPHP Medicaid Copayment Guide 3-16
- Emergency Procedures 3-16
- Reporting Communicable Diseases, Developmental Delays, and Abuse 3-17
- Access and Availability Standards 3-17
- Expect Medicaid Managed Care Test Calls 3-19
- Required Ownership Information Disclosure 3-19
- Certification Regarding Individuals Debarred or Suspended 3-19
- Collection and Disclosure of Criminal Conviction Information 3-19
- Early Periodic Screening, Child Teen Health Program, and Adolescent Preventive Services 3-20
- Domestic Violence Resources 3-20
- Welfare Reform 3-23
- Sterilization Consent Form 3134 3-24
- Acknowledgement of Receipt of Hysterectomy Information Form 3113 3-25

DRAFT

- POAM section 3 contains comprehensive information about CDPHP Government Programs.
- Very useful resource for needed information.
- Still in draft form as it is being reviewed by the state as part of HARP readiness. Final version to be posted upon state sign off.

Medicaid Products Overview

Revised January 2016

Medicaid Covered Services

CDPHP Medicaid Products	CDPHP Select Plan		CDPHP HARP (effective 7/1/16)	New York State Pays
Member Eligibility within Product	Not SSI or SSI Related	SSI or SSI-Related	HARP	Medicaid Fee for Service
Inpatient Hospital Services	Covered, unless admit date precedes Effective Date of Enrollment	Covered, unless admit date precedes Effective Date of Enrollment	Covered, unless admit date precedes Effective Date of Enrollment	Stay covered only when admit date precedes Effective Date of Enrollment
Inpatient Stay Pending Alternate Level of Medical Care	Covered	Covered	Covered	
Physician Services	Covered	Covered	Covered	
Nurse Practitioner Services	Covered	Covered	Covered	
Midwifery Services	Covered	Covered	Covered	
Preventive Health Services	Covered	Covered	Covered	
Second Medical/ Surgical Opinion	Covered	Covered	Covered	
Laboratory Services	Covered Includes HIV phenotypic, virtual phenotypic and genotypic drug resistance tests and viral tropism testing	Covered Includes HIV phenotypic, virtual phenotypic and genotypic drug resistance tests and viral tropism testing	Covered Includes HIV phenotypic, virtual phenotypic and genotypic drug resistance tests and viral tropism testing	Covered through 3/31/14, HIV phenotypic, virtual phenotypic and genotypic drug resistance tests and viral tropism testing
Radiology Services	Covered	Covered	Covered	
Prescription and Non-Prescription (OTC) Drugs, Medical Supplies, and Enteral Formula	Covered Coverage excludes hemophilia blood factors.	Covered Coverage excludes hemophilia blood factors. Until July 1, 2016, Coverage excludes Risperidone microspheres (Risperdal® Consta®,) paliperidone palmitate (Invega® Sustenna®), Abilify Maintena™ and olanzapine (Zyprexa® Relprevv™).	Covered Coverage excludes hemophilia blood factors. Includes Risperidone microspheres (Risperdal® Consta®,) paliperidone palmitate (Invega® Sustenna®), Abilify Maintena™ and olanzapine (Zyprexa® Relprevv™).	Hemophilia blood factors covered through MA FFS. Until July 1, 2016, coverage for SSI recipients Includes Risperidone microspheres (Risperdal® Consta®,) paliperidone palmitate (Invega® Sustenna®), Abilify Maintena™ and olanzapine (Zyprexa® Relprevv™).
Smoking Cessation Products	Covered	Covered	Covered	

DRAFT

- The covered services chart shows benefits and any limitations for each product line, or whether the benefit is still carved out.

Medicaid Products Overview

NYS Allowable Billing Combinations of OMH/OASAS State Plan Services and BH HCBS

BH HCBS/State Plan Services	OMH Clinic/OLP	OASAS Clinic	OASAS Opioid Treatment Program	OMH ACT	OMH PROS	OMH IPRT/CDT	OMH Partial Hospital	OASAS Outpatient Rehab
PSR	Yes	Yes	Yes	No	No	No	Yes	No
CPST	No	No	No	No	No	No	Yes	No
Habilitation	Yes	Yes	Yes	No	No	No	Yes	No
Family Support and Training	Yes	Yes	Yes	No	No	Yes	Yes	Yes
Education Support Services	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes
Peer Support Services	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes
Employment Services	Yes	Yes	Yes	No	No	Yes	Yes	Yes

Medicaid Products Overview

Access and Availability Standards

Appointment Type	Standard
Well child care	Within four (4) weeks of request
Adult Baseline and routine physicals	Within twelve (12) weeks from enrollment. (Adults >21 years)
Routine non-urgent, preventive appointments, except as otherwise provided	Within four (4) weeks of request
Initial family planning visits	Within two (2) weeks of request
Initial prenatal visit	Within three (3) weeks during first trimester, within two (2) weeks during the second trimester and within one (1) week during the third trimester
Initial PCP office visit for newborns	Within two (2) weeks of hospital discharge
Non-urgent "sick" visit	Within forty-eight (48) to seventy-two (72) hours of request, as clinically indicated
For emergency care	Immediately upon presentation at a service delivery site
For CPEP, inpatient mental health and Inpatient Detoxification Substance Use Disorder services and Crisis Intervention services	Immediately upon presentation at a service delivery site
For urgent care	Within twenty-four (24) hours of request

- Please take special note of the state's requirements for appointment access and availability standards.
- Both CDPHP and the state (via a vendor) will conduct access studies to determine if providers are meeting these timeframes.

Medicaid Products Overview

Access and Availability Standards *(continued)*

Appointment Type	Standard
For urgently needed Substance Use Disorder inpatient rehabilitation services, stabilization treatment services in OASAS certified residential settings and mental health or Substance Use Disorder outpatient clinics, Assertive Community Treatment (ACT), Personalized Recovery Oriented Services (PROS) and Opioid Treatment Programs	Within twenty-four (24) hours of request
Specialist referrals (not urgent), except as otherwise provided	Within four (4) to six (6) weeks of request
Behavioral health specialist referrals (not urgent): A. For Continuing Day Treatment, Intensive Psychiatric Rehabilitation Treatment programs and Rehabilitation services for residential Substance Use Disorder treatment services B. For PROS programs other than clinic services	Within two (2) to (4) weeks of request Within two (2) weeks of request
Pursuant to an emergency, hospital discharge or release from incarceration, where the Contractor is informed of such release, mental health or Substance Use Disorder follow-up visits with a Participating Provider (as included in the Benefit Package)	Within five (5) days of request, or as clinically indicated
Non-urgent mental health or Substance Use Disorder visits with a Participating Provider that is a Mental Health and/or Substance Use Disorder Outpatient Clinic, including a PROS clinic	Within one (1) week of request
Provider visits to make health, mental health and substance abuse assessments for the purpose of making recommendations regarding a recipient's ability to perform work when requested by a LDSS	Within ten (10) days of request by CDPHP member

DRAFT

- Requiring any paperwork from a Medicaid member **prior to the granting of an appointment** is considered by DOH to be a barrier to care and could represent a discriminatory practice.
- This includes copies of medical records, signatures on opiate use agreements, etc.

Medicaid Products Overview

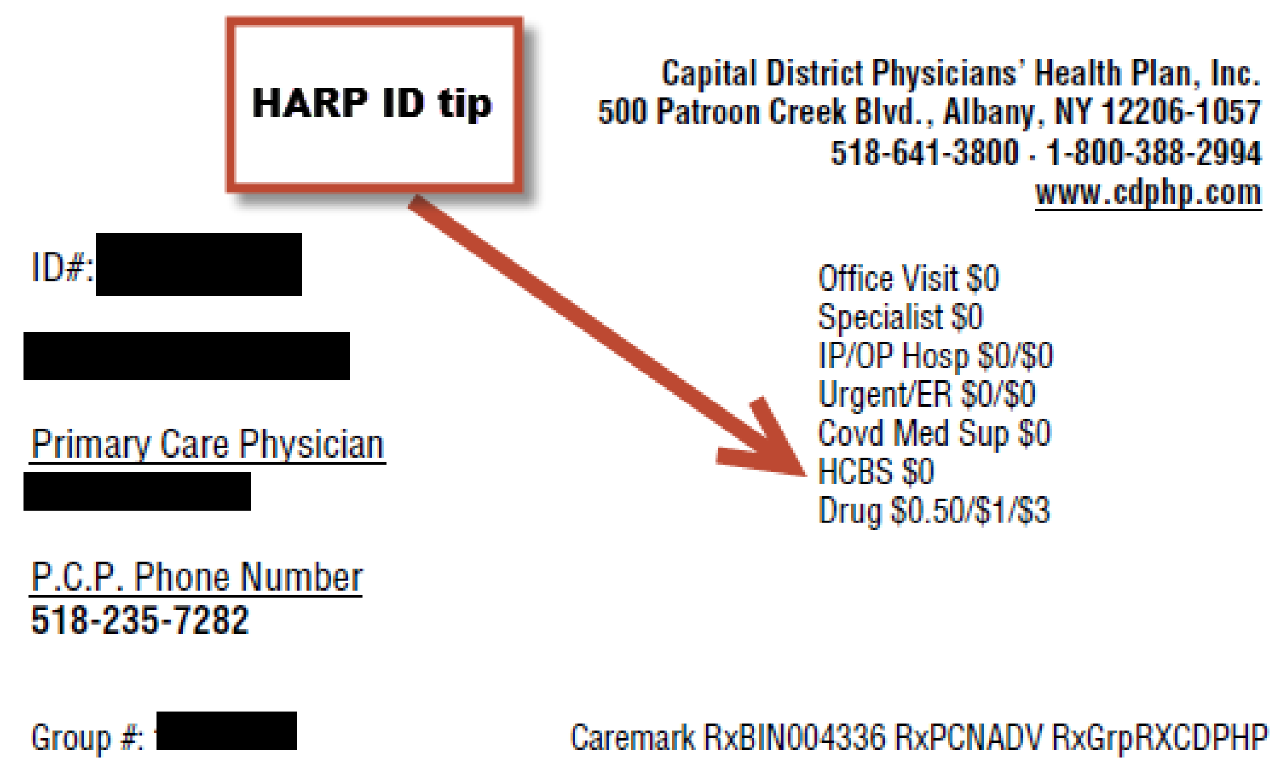
Behavioral Health Home and Community Based Services Access and Availability Standards

Appointment Type	Standard
Short Term and Intensive Crisis Respite	Within twenty-four (24) hours of request
Psychosocial Rehabilitation, Community Psychiatric Support and Treatment, Habilitation Services, Family Support and Training	Within two (2) weeks of request, unless the appointment is pursuant to an emergency or hospital discharge or release from incarceration, in which case the standard shall be within five (5) days of request, or as clinically indicate
Educational and Employment Support Services, including Pre-Vocational Services	Within two (2) weeks of request
Peer Supports Services	Within one (1) week of request, unless the appointment is pursuant to an emergency or hospital discharge, in which case the standard shall be within five (5) days, or if the Peer Support Services are needed urgently for symptom management, in which case an appointment must be available within twenty-four (24) hours

For future reference for HCBS services effective October 1, 2016

Medicaid Products Overview

- Select Plan and HARP ID cards
  - The cards are the same with one exception: HARP ID cards will list HCBS as a covered service with no copay.



Medicaid Products Overview

- Health Homes (HH)
  - CDPHP enters into administrative agreements with state designated Health Homes for care coordination services for Select Plan and HARP.
  - We have agreements with several local Health Homes and are working to contract with more by July 1.
  - The state has published extensive guidance on all aspects of Health Home and MCO requirements:
    - Required contract language, payment, data sharing
    - Division of responsibilities
    - HH provide conflict free assessment(s) for HCBS eligibility
    - HH prepare comprehensive plans of care for MCO review and approval

Medicaid Products Overview

- CDPHP has established a new toll-free number (1-844-523-5961) for Health Homes to use to gain plan assistance to locate members. This line will be operational by July 1, 2016.
- We plan to engage Health Homes more regularly to facilitate ongoing discussions of member engagement, care coordination, HCBS assessments, handling complex members, gaining input on where additional assistance is needed, sharing data, addressing concerns, and developing best practices.
- Early deliverables: Update our contracts and get new contracts established before July; provide education sessions on key topics. More to follow on these opportunities.

Billing Manual – We All Need to Use It

New York State Health and Recovery Plan (HARP) / Mainstream Behavioral Health Billing and Coding Manual

For Individuals Enrolled in Mainstream Medicaid Managed Care Plans And HARPS

http://www.omh.ny.gov/omhweb/bho/harp-mainstream-billing-manual.pdf

Rate Sheet – OMH Services

Billing Behavioral Health Medicaid Services Under Managed Care

Billing Behavioral Health Medicaid Services Under Managed Care

Behavioral Health Billing Guidance* (September 1, 2015) – The "New York State HARP Mainstream BH Billing and Coding Manual" provides billing mechanics for all the Medicaid fee-for-service "government rate" services under both the Office of Mental Health and the Office of Alcoholism and Substance Abuse Services. This manual should be reviewed in conjunction with the four items below.

Behavioral Health Home and Community Based Services (BH HCBS) Fee Schedule* (January 29, 2016) – This shows the required coding combinations for providers to bill the Plan for the provision of these services.

Coding Taxonomy* (January 29, 2016) – This file provides the required coding construct for billing the OMH/OASAS government rates services.

Health and Recovery Plan (HARP) BH HCBS Rate Codes* – These are the codes that the HARP plans and HSNPs will be using to bill Medicaid for HCBS services that are provided to HARP enrollees (or HSNP enrolled HARP-eligibles).

OMH Government Rates Table * (February 19, 2016)

NEW YORK STATE OF OPPORTUNITY. | Office of Mental Health

Rate Table of OMH Government Rates for the Behavioral Health Implementation (including HARPs)

Date: 02/18/2016

Prov Doing Business As Name	Prov ID	Locator Cd	NPI	Zip + 4	Rate Beg Dt	Rate End Dt	Service Type	Rate Cd
ALBANY COUNTY COMM SVS BOARD	02359837	003	1609935642	12202-2011	1-Apr-15	31-Dec-99	ACT	4508
ALBANY COUNTY COMM SVS BOARD	02359837	003	1609935642	12202-2011	1-Apr-15	31-Dec-99	ACT	4509
ALBANY COUNTY COMM SVS BOARD	02359837	003	1609935642	12202-2011	1-Apr-15	31-Dec-99	ACT	4511
ALLEGANY REHABILITATION ASSOC CDT	02977080	005	1295740512	14895-9332	1-Apr-15	31-Dec-99	PROS	4510
ALLEGANY REHABILITATION ASSOC CDT	02977080	005	1295740512	14895-9332	1-Apr-15	31-Dec-99	PROS	4520
ALLEGANY REHABILITATION ASSOC CDT	02977080	005	1295740512	14895-9332	1-Apr-15	31-Dec-99	PROS	4521

Claims Coding Crosswalks

Billing Behavioral Health Medicaid Services Under Managed Care

Billing Behavioral Health Medicaid Services Under Managed Care

Behavioral Health Billing Guidance* (September 1, 2015) – The "New York State HARP Mainstream BH Billing and Coding Manual" provides billing mechanics for all the Medicaid fee-for-service "government rate" services under both the Office of Mental Health and the Office of Alcoholism and Substance Abuse Services. This manual should be reviewed in conjunction with the four items below.

Behavioral Health Home and Community Based Services (BH HCBS) Fee Schedule* (January 29, 2016) – This shows the required coding combinations for providers to bill the Plan for the provision of these services.

Coding Taxonomy* (January 29, 2016) – This file provides the required coding construct for billing the OMH/OASAS government rates services.

Health and Recovery Plan (HARP) BH HCBS Rate Codes* – These are the codes that the HARP plans and HSNPs will be using to bill Medicaid for HCBS services that are provided to HARP enrollees (or HSNP enrolled HARP-eligibles).

OMH Government Rates Table * (February 19, 2016)

http://www.omh.ny.gov/omhweb/bho/billing-services.html

Claims Crosswalk Example

Program	Rate Cod	Rate Code / Service Title	Px Cod	Px Code Description	Modifier	Units of Servic	Specialty Cod	Notes
Assertive Community Treatment (ACT)	4508	ACT Intensive Full Payment	H0040	Assert comm tx pgm per diem	None	6+	816: OMH ACT	Billed on a monthly basis. Use per diem code, with number of contacts during month in the unit field. Each unit represent one contact of at least 15 minutes.
	4509	ACT Intensive Part Payment	H0040	Assert comm tx pgm per diem	U5	2-5	816: OMH ACT	Billed on a monthly basis. Use per diem code, with number of contacts during month in the unit field. Each unit represent one contact of at least 15 minutes.
	4511	ACT Inpatient	H0040	Assert comm tx pgm per diem	U1, U5	2+	816: OMH ACT	Billed on a monthly basis. Use per diem code, with number of contacts during month in the unit field. Each unit represent one contact of at least 15 minutes.

Rate Code should be submitted on claim

We pay based on Procedure Code and Modifier combination

Billing Guide Rules – PROS Example

Service	Frequency	Modifiers?	Interesting Fact
PROS	Monthly Case Rate	Yes – services have unique HCPCs and Modifier combos	Claims use last day of the month as DOS All claim line levels must be last day of month Maximum 5 units PROS/day

- **Modifiers are key for payment, see chart below:**

Rate Code	Procedure Code	Modifier	Units
4520	H2019, therapy, per 15 min	U1	2-12
4521	H2019, therapy, per 15 min	U2	13-27
4522	H2019, therapy, per 15 min	U3	28-43
4523	H2019, therapy, per 15 min	U4	44-60
4524	H2019, therapy, per 15 min	U5	61+

- Component add-ons permitted, see billing guide

Billing Guide Rules – ACT Example

Service	Frequency	Modifiers?	Interesting Fact
ACT	Monthly Rates	Yes – services have unique HCPCs and Modifier combos	Claims use last day of the month as DOS Three monthly rate options; full, partial, inpatient

- Modifiers are key for payment, see below

Comma indicates both modifiers required

Rate Code	Service	Procedure Code	Modifier	Units	Comments
4508	ACT Intensive Full Payment	H0040	None	6+	Per diem code, 6 contacts required
4509	ACT Intensive Partial Payment	H0040	U5	2-5	Per diem code, 2 contacts required
4511	Act Inpatient	H0040	U1, U5	2-3	Inpt stay and 2 contacts required

Behavioral Health Pharmacy Program

- Goal: Work collaboratively with providers to improve the quality and efficacy of the prescribing of behavioral health medication, and to improve the health outcome of our members.
- Components:
  - Develop and maintain policies
  - Medication reviews
  - Education resource
  - Data analysis and reporting
- Contact information
  - Tara M. Thomas, R.Ph, MBA, BCPS

    Tara.Thomas@cdphp.com

Community Care Behavioral Health Organization (CCBH)

Kelly Lauletta, LCSW

Regional Director

What is the Community Care Behavioral Health Organization?

- Incorporated in 1996 primarily to support Pennsylvania
- Part of the UPMC Insurance Services Division
- 501(c)(3) nonprofit behavioral health managed care organization
- Licensed as risk-bearing PPO
- Implemented HealthChoices in 39 counties (as of July 1, 2013) in Pennsylvania beginning in 1999
- Experience with full-risk, shared-risk, and Administrative Services Only (ASO) contracts

CCBHs Work in New York

- Implemented a Care Monitoring Initiative in New York City (2009)
  - New York State Office of Mental Health (OMH)
  - New York City Department of Health & Mental Hygiene (DOHMH)
- Awarded 16-county Hudson River Region in Behavioral Health Organization (BHO) Initiative (2012)
  - New York Office of Mental Health (OMH)
  - New York State Office of Alcoholism and Substance Abuse Services (OASAS)
- Partnered with CDPHP to serve HARP members beginning July 1, 2016

How Will CCBH Work with HARP Members?

- CCBH will engage HARP members upon hospitalization and perform an immediate needs assessment.
  - If the member is already enrolled in the Health Home, the Health Home will be notified.
  - If the member is NOT enrolled, a referral will be facilitated.
- If a Health Home is at capacity, or expresses difficulty in engaging the member promptly, CCBH will work with the member until Health Home is engaged.
- CCBH will work with Health Home care managers to assure the members ongoing needs are met.

Integrated Case Management

A Collaborative Approach to Manage Physical and Mental Health

Jane Wilson

Administrator, Care Management

Why is Integrated BH and Medical Case Management Important?

Comorbidity between medical and mental conditions is the rule rather than the exception.

- In a national study published in 2011, 34 million adults or 17% of the adult population had comorbid mental and medical conditions.
- System fragmentation leads to lower quality and high cost for individuals with comorbid conditions.
- Medical conditions may lead to mental disorders, and mental disorders may place a person at risk for medical conditions.

Source: Robert Wood Johnson Foundation

What Role Does the Health Care System Play In This Problem?

- Psychiatric and medical conditions are overlapping and interrelated, although the health care systems and services are often separated.
- Medicaid redesign intends to create greater integration of services with the implementation of HARP, Health Homes, and DSRIP.
- MCOs play an important role in this solution.

How Does CDPHP Plan to Address This National Crisis?

- The CDPHP medical and behavioral case management teams will use an integrated approach to meet physical and behavioral health needs.
- A person-centered approach is essential.
- Care teams cannot work in silos.
- We will use a feet to the street integrated model.
- Together, we will strengthen the co-managed plan of care through the use of community based resources.

Let's Talk About Our Medical CM Team

Multidisciplinary Team

- RN and social work medical case managers
- Nutritionist
- Certified Diabetes Educator
- Certified Asthma Educators

It’s All About the Relationship

Embedded face-to-face medical case management is offered in a variety of settings:

- High-volume EPC practices
- Large tertiary care facilities
- Community sites
- Members’ homes

Let’s Talk About Our Case Management Interventions

Not just better health care, but a better health care experience.

- Increased usage of preventative services
- Reduction of unnecessary hospitalizations and ER visits
- Assistance navigating the health care system-transportation
- Linkage to community-based services
- Disease-specific education
- Linkage to primary care
- Education on available benefits and alternatives
- Integration with behavioral health services

Example of True Integration

- 49 y/o chronic alcohol use, anxiety, depression, GERD, and chronically homeless
- New diagnosis of lung cancer, underwent right thoracotomy and upper right lobectomy
- Linkage to housing resource via community resources
- Assisted with getting sanction lifted, allowing member to receive additional supports
- Now assisting member through chemotherapy treatments and long-term sobriety

Utilization Management

Debbie Manginelli, UM Compliance Lead

John Arcuri, Manager, Behavioral Health

Utilization Management Rules

CDPHP®

- Criteria for coverage of medical and behavioral health services are documented in the resource coordination (RC) policies, which can be accessed via the provider portal at www.cdphp.com.
- Additional criteria specific to Select Plan and HARP can be found at the end of each policy under the Government Programs section.
- The provider is responsible for obtaining the necessary prior authorization/concurrent review.
- Authorization requirements are identified in the following guideline documents:
  - Prior Authorization Guideline
  - Concurrent Review Guideline

Prior Authorization Guidelines

CDPHP PRIOR AUTHORIZATION GUIDELINE

The following guideline outlines those services that require prior authorization through the CDPHP® resource coordination or behavioral health department. All services outlined in this guideline are subject to medical necessity and benefit availability as defined in the enrollee's contract and/or employer-sponsored Summary Plan Description (SPD) and Benefit Design Document (BDD). Coverage of a service is subject to the member's eligibility, specific contract benefits, and CDPHP medical/behavioral health policy. Requests for a service that do not meet criteria outlined in a CDPHP policy, or for an extension beyond what has been approved by CDPHP, should be directed to the resource coordination (RC) department at (518) 641-4100/1-800-274-2332. Inquiries regarding behavioral health services should be directed to the behavioral health (BH) department at (518) 641-3600/1-888-320-9584.

Note: Effective March 1, 2013, emergency room services do not require prior authorization and are paid without review.

DRAFT

Policy Reference/ Type of Service Requiring Prior Authorization Effective Date: 7/1/16	Contact Department	HMO	UBI PPO/HDPPO Network Benefits: In	Out	UBI EPO/ HDEPO	UBI Small Group	Select Plan/ HARP	Child Health Plus	Medicare Choices HMO	PPO Network Benefits In	Out
Abdominoplasty, Panniculectomy (tummy tuck) & Lipectomy (liposuction) Procedures : 1370/20.000443	RC	Yes	No	No	No	No	Yes	Yes	Yes	No	No
Ambulance & Medical Transport: 1370/20.000092 (1) Non-emergency (non-ambulance) transportation	RC	Non-Covered	Non-Covered	Non-Covered	Non-Covered	Non-Covered	*Non-Covered	Non-Covered	Non-Covered	Non-Covered	Non-Covered
(2) Non-emergency ambulance transport; non-airborne, inter-facility		Yes	No	No	No	Yes	No	No	No	No	No
(3) Non-emergency, ambulance transport; non inter-facility		Non-Covered	Non-Covered	Non-Covered	Non-Covered	Non-Covered	*Non-Covered	Non-Covered	Yes/No	Yes/No	No
(4) Non-emergency air ambulance (See examples below)		Yes	Yes	Yes	Yes	Yes	*Non-Covered	Non-Covered	Yes	Yes	No

(1) Non-emergency transportation	Non-ambulance transportation to include medicab, ambulette, mini-bus, taxi, wheelchair van, or stretcher van.
(2) Non-emergency ambulance transport; non-airborne, inter-facility	Ambulance transportation from hospital to hospital for an inpatient stay or outpatient procedure; or from hospital to approved inpatient rehabilitation or skilled nursing facility.
(3) Non-emergency ambulance transport; non inter-facility	[Yes] Authorization for ambulance transport to or from a member's home, physician's office, or outpatient facility is required. [No] Authorization for ambulance transport to or from a skilled nursing facility is not required.
(4) Non-emergency air ambulance	Transfer of member from an out-of-area hospital to an in-network hospital. (*) Non-covered by CDPHP. Transportation services are administered under the Medicaid fee-for-service program.

The provider is responsible for seeking prior authorization for services indicated within this guideline for the following CDPHP products: HMO, Medicare Choices HMO, Select Plan/HARP and Child Health Plus. The member is responsible for seeking authorization for such services for the following CDPHP UBI products: PPO and HDPPO (in- and out-of-network), and EPO and HDEPO.

Prior Authorization Guidelines – Continued

Policy Reference/ Type of Service Requiring Prior Authorization Effective Date: 7/1/16	Contact Department	HMO	UBI PPO/HDPPO Network Benefits:		UBI EPO/ HDEPO	UBI Small Group	Select Plan/ HARP	Child Health Plus	Medicare Choices		
			In	Out					HMO	PPO Network Benefits In	PPO Network Benefits Out
Ambulatory Mental Health Programs for Adults, 1370/20.000XXX	BH										
• Assertive Community Treatment		N/A	N/A	N/A	N/A	N/A	Yes	N/A	N/A	N/A	N/A
• Continuing Day Treatment		N/A	N/A	N/A	N/A	N/A	Yes	N/A	N/A	N/A	N/A
• Personalized Recovery Oriented Services(PROS):											
• Admission		N/A	N/A	N/A	N/A	N/A	Yes	N/A	N/A	N/A	N/A
• Active Rehabilitation		N/A	N/A	N/A	N/A	N/A	Yes	N/A	N/A	N/A	N/A
Bariatric Surgery (surgical procedure for weight loss): **1370/20.000061** • Requests for any bariatric surgical procedure to include revision of a failed primary surgery or conversion to another surgical procedure	RC	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No
Behavioral Health Home and Community Based Services for Adults, 1370/20.000XXX • All services	BH	N/A	N/A	N/A	N/A	N/A	SP – N/A HARP - yes	N/A	N/A	N/A	N/A
Bone Growth Stimulator (non-invasive device to aid in healing of fractures)**, Electromagnetic, Ultrasonic: 1370/20.000044**	RC	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
Cardiac Rehabilitation (medically supervised program to help in the recovery from a heart condition or surgery)**: 1370/20.000069** • For additional visits beyond maximum of 36 visits.	RC	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No
• Intensive cardiac rehabilitation program		N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	No	No
Cochlear Implant (implantable hearing device)**: 1370/20.000446**	RC	Yes	No	No	No	No	Yes	Yes	Yes	No	No

DRAFT

The provider is responsible for seeking prior authorization for services indicated within this guideline for the following CDPHP products: HMO, Medicare Choices HMO, Select Plan/HARP and Child Health Plus. The member is responsible for seeking authorization for such services for the following CDPHP UBI products: PPO and HDPPO (in- and out-of-network), and EPO and HDEPO.

Concurrent Review Guidelines - NEW

CDPHP CONCURRENT REVIEW GUIDELINE

The following guideline outlines those services that require concurrent review. All services outlined in this guideline are subject to medical necessity and benefit availability as defined in the enrollee's contract and/or employer-sponsored Summary Plan Description (SPD) and Benefit Design Document (BDD). Coverage of a service is subject to the member's eligibility, specific contract benefits, and CDPHP medical/behavioral health policy. Requests for a service that do not meet criteria outlined in a CDPHP policy, or for an extension of services beyond what has been approved by CDPHP, should be directed to the resource coordination (RC) department at (518) 641-4100/1-800-274-2332. Inquiries regarding behavioral health services should be directed to the behavioral health (BH) department at (518) 641-3600/1-888-320-9584.

Policy Reference/ Type of Service Requiring Concurrent Review Effective Date: 7/1/16	Contact Department	HMO	UBI PPO/HDPPO Network Benefits:		UBI EPO/ HDEPO	UBI Small Group	Select Plan/ HARP	Child Health Plus	Medicare Choices		
			In	Out					HMO	PPO Network Benefits In	Out
Ambulatory Mental Health Programs for Adults, 1370/20.000XXX	BH										
• Assertive Community Treatment		N/A	N/A	N/A	N/A	N/A	Yes	N/A	N/A	N/A	N/A
• Continuing Day Treatment		N/A	N/A	N/A	N/A	N/A	Yes	N/A	N/A	N/A	N/A
• Personalized Recovery Oriented Services(PROS): Active rehabilitation		N/A	N/A	N/A	N/A	N/A	Yes	N/A	N/A	N/A	N/A
Behavioral Health Home and Community Based Services for Adults, 1370/20.000XXX • All services	BH	N/A	N/A	N/A	N/A	N/A	SP – N/A HARP - Yes	N/A	N/A	N/A	N/A
Home Health Care/TeleHomecare/ Personal Care/Personal Emergency Response System: 1370/20.000048											
• Medical services, including home infusion therapy	RC	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
• Mental health services	BH	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
Inpatient Continued Stay											
• Medical	RC	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
• Behavioral Health	BH	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No

The provider is responsible for seeking prior authorization for services indicated within this guideline for the following CDPHP products: HMO, Medicare Choices HMO, Select Plan/HARP and Child Health Plus. The member is responsible for seeking authorization for such services for the following CDPHP UBI products: PPO and HDPPO (in- and out-of-network), and EPO and HDEPO.

Page 1 of 3

Concurrent Review - Outlier Overview

- In addition to authorization concurrent review, CDPHP will also conduct outlier concurrent review.
- Outlier concurrent review identifies both under and over utilization of services.
  - Low Utilization
    - Review to understand progress or identify barriers to engagement.
  - High Utilization
    - Review conducted for level of care and treatment plan, interventions, and quality of care.
- Providers should understand expected number of visits per treatment episode to help identify and manage outliers.

RC Policies Related to Behavioral Health Services

- Review Process for Resource Coordination (1370/20.000213)
- Concurrent Review (1370/20.000174)
- Behavioral Health Assessment & Triage (1370/20.000462)
- Inpatient Detoxification: Medically Supervised Level of Care (1370/20.000475)
- Residential Treatment Facilities for Mental Health and Substance Use Disorder (1370/20.000482)
- Partial Hospital Programs (PHP) & Intensive Outpatient Programs (IOP) (1370/20.000459)
- Ambulatory Mental Health Programs for Adults (1370/20.000488) - NEW
- Behavioral Health Home and Community Based Services (1370/20.000489) - NEW

Ambulatory Mental Health Programs for Adults

- This policy identifies criteria for the following programs:
  - Assertive Community Treatment (ACT)
  - Continuing Day Treatment (CDT)
  - Personalized Recovery Oriented Services (PROS)

Assertive Community Treatment (ACT)

- Program for members with a severe and persistent mental illness that seriously impairs functioning in the community. Priority is given to:
  - Members with schizophrenia, other psychotic disorders, bipolar disorder, and/or major chronic depression, because these illnesses more often cause long-term psychiatric disability.
  - Members with continuous high service needs that are not being met in more traditional service settings.
- Members with a primary diagnosis of a personality disorder(s), substance use disorder, or mental retardation are not appropriate for ACT.
- Prior authorization and concurrent review is required.

Assertive Community Treatment (ACT) - Continued

- ACT referrals may be submitted by phone, fax, mail, in person (i.e.: inpatient staff request through CDPHP BH care coordinator), or through the CDPHP provider portal.
- CDPHP will review the referral and request additional information if needed.
  - If review determines criteria for ACT are not met, CDPHP will reach out to requesting provider to discuss alternate service plan that will meet member’s needs.
  - If review determines criteria for ACT have been met, CDPHP will send the requesting provider and member a level of care approval letter and a list of in-network ACT teams.
- Decision will be made and notification provided within 24 hours of receipt of the referral.
- When approval is received, the referring provider will need to complete and submit the ACT application, including the level of care approval letter from CDPHP and list of in-network ACT teams, to the single point of access (SPOA).

Assertive Community Treatment (ACT) - Continued

- SPOA determines urgency of member's need for ACT.
  - If SPOA does not agree with the ACT level of care approval, they will review the application with CDPHP and arrive at a consensus related to level of care for the member.
- SPOA completes the referral process and assigns the member to an ACT team.
  - If there are no open slots, the member is placed on a waiting list. The referring provider, CDPHP, and Health Home (if applicable) are notified of ACT team wait list. The member will be assigned to an ACT team when there is an opening.
- Authorization is completed. Verbal and written notification are provided to the member and referring provider.
  - If member has been approved for HCBS services, these authorizations will be terminated as these are a duplication of services that are received from ACT.

Continuing Day Treatment (CDT)

- Program provides seriously mentally ill adults with the skills and supports necessary to remain in the community or work toward a more independent level of functioning. Participants may attend several days per week with visits lasting more than an hour.
- Requests for CDT may be submitted by phone, fax, mail, or through the CDPHP provider portal.
- CDPHP will review the submitted documentation and request additional information if needed.
- Decision will be made and notification provided within three business days of receipt of complete information, but no later than 14 calendar days from receipt of the request. Verbal and written notification are provided to the member, referring provider, service provider, and PCP.

Personalized Recovery Oriented Services (PROS)

- Comprehensive recovery oriented program for individuals with severe and persistent mental illness. Through a single plan of care, the program model integrates treatment, support and rehabilitation in a manner that facilitates the individual's recovery.
- The PROS model is person-centered, strength-based, and comprised of a menu of group and individual services designed to assist a participant to overcome mental health barriers and achieve a desired life role.
- There are three stages of PROS:
  - Pre-admission
  - Admission
  - Active Rehabilitation

Personalized Recovery Oriented Services (PROS) - Continued

Pre-admission

- PROS provider conducts pre-admission visits with member and develops an Initial Service Recommendation (ISR). Prior authorization is not required for these visits.
- The ISR is submitted to CDPHP, requesting prior authorization for admission to PROS.
  - Member continues at this level until PROS admission review is completed.

Admission

- CDPHP reviews the submitted ISR and requests additional information if needed.
- Decision is made and notification provided within three business days of receipt of complete information, but no later than 14 calendar days from receipt of the request. Verbal and written notification are provided to the member, PROS provider, and PCP.

Personalized Recovery Oriented Services (PROS) - Continued

- If member has been approved for Rehabilitation, Habilitation, Individual Employment Support, and/or Family Support/Training HCBS services, these authorizations will be terminated as these are a duplication of services that are received from PROS.

- The PROS provider conducts visits with member and develops an Individual Recovery Plan (IRP) within 60 days of admission.
  - Services identified in the IRP are Community Rehabilitation and Support (CRS) services, and may include additional services such as: Intensive Rehabilitation (IR), Ongoing Rehabilitation and Support (ORS), and Clinical Treatment.
- The IRP is submitted to CDPHP, requesting prior authorization for active rehabilitation.

Active Rehabilitation

- CDPHP reviews the submitted IRP and requests additional information if needed.
- Decision is made and notification provided within three business days of receipt of complete information, but no later than 14 calendar days from receipt of the request. Verbal and written notification are provided to the member, ordering provider, PROS provider, and PCP.
- PROS provider conducts authorized PROS services. Prior to the end of the authorized period, PROS provider submits request for concurrent review to continue providing PROS services.

BH Home and Community Based Services

- The Behavioral Health Home and Community Based Services (1370/20.000489) policy identifies criteria for the following behavioral Health Home and community based services:
  - Rehabilitation Services (PSR & CPST)
  - Habilitation Services
  - Crisis Intervention (Respite)
  - Educational Support Services
  - Individual Employment Support Services
  - Empowerment Services – Peer Supports
  - Family Support and Training

BH Home and Community Based Services (HCBS) – Continued

- Provides opportunities for eligible HARP members with mental illness and/or substance use disorder (SUD) to receive services in his/her own home or community through a person-centered plan of care that meets the member's needs.
- To determine eligibility for these services, Health Home completes brief assessment to determine if Tier 1 or Tier 2 HCBS services are needed.
  - ➢ Tier 1 – employment services, education support services, peer support services
  - ➢ Tier 2 – all Tier 1 services and rehabilitation services, habilitation services, crisis respite, and family support and training services

Note: Member is not required to enroll with a Health Home, but must work with a Health Home for assessment and plan of care development in order to receive HCBS services.

BH Home and Community Based Services (HCBS) – Continued

- Member and Health Home have a person-centered discussion about the member's goal(s) and how State plan services (i.e. ACT, PROS) or HCBS services may address the member's needs.
- Health Home works with the member, current providers, other collaterals, and CDPHP to identify new service needs, and identify new providers, as needed, to update the plan of care.
- Health Home completes HCBS Plan of Care template and submits to CDPHP for *Level of Service Determination*.
- CDPHP reviews plan of care and issues a *Level of Service Determination*. If approved, CDPHP authorizes referral to HCBS providers, selected by the member, to for evaluation and to determine frequency, scope and duration of HCBS service.

BH Home and Community Based Services (HCBS) – Continued

- **On or after October 1, 2016**, HCBS provider submits frequency, scope, and duration for HCBS services to CDPHP for authorization review.

- CDPHP reviews the submitted documentation and renders determination related to proposed frequency, scope, and duration for HCBS services

- Within 90 days of completing the brief assessment, the Health Home care manager completes the full assessment and plan of care, obtaining needed signatures, and provides copy to CDPHP.

LOCADTR

- LOCADTR is used for determinations on **all** levels for substance use disorder treatment for Medicaid and HARP.
- Designed to guide decision making regarding the appropriate level of care for a client.
- Ensures all in need of treatment have access to care and are placed in a community setting that will provide a safe and effective treatment.
- Allows NYS to analyze data to assess provider and system level performance and inform needs assessments.
- Level of care is determined by:
  - ➢ Needs for crisis or detox services (i.e., medical complications from withdrawal)
  - ➢ Risk factors (i.e., severe psychological and medical conditions)
  - ➢ Resources available (i.e., social and family network supportive of recovery goal)

Managed Care Use of LOCADTR

- CDPHP will collect assessment information as currently required and will request the LOCADTR, that supports the requested LOC, from the provider.
- If CDPHP does not agree with the LOC recommendation based on information received, then a separate LOCADTR will be completed.
- CDPHP will contact the provider to walk through the questions and determine differences in how the assessment is being interpreted.
- Ideally, this should be a clinically-oriented conversation that will result in a mutually agreed upon LOC.
  - ➢ If agreement cannot be reached, the case is brought to a medical director for review.
    - If the medical director determines the LOC recommended by the provider is not appropriate, an adverse determination will be issued along with appeal rights.
- CDPHP is responsible for ensuring the recommended level of care is available to the member. Otherwise, the next highest level of care will be approved.

Requesting Authorization

- Four new authorization forms are being added to the Provider section of www.cdphp.com.

- These forms will be located under:
  - ➢ Get Your Job Done
    - Forms and Documents
      - ✓ Behavioral Health

        and

      - ✓ Prior Authorization

Behavioral Health

- Provider Responsibilities Overview
- Avoiding Common E&M Coding Mistakes
- Exchange of Information
- Medical Record Tip Sheet
- Suboxone Induction, Stabilization, and Maintenance at Conifer Park

Claims

- 835 Electronic Remittance Advice Enrollment Request
- 835 Transaction Companion Guide
- 837 Access Information Request
- 837 Transaction Companion Guide
- Provider Review Form
- Tutorial: How to Complete the Provider Review Form
- Provider Distribution Program Order Form

Credentialing

- CAQH Application Instructions and Checklist for Practitioners
- CAQH Application Instructions and Checklist for Adjuncts
- Data Collection Form
- Information Change Form

Inpatient Clinical Review

- Initial Stay at a Hospital
- Initial Stay for Rehabilitation, LTAC, and SNF
- Continued Stay at Rehabilitation, Hospital, and SNF

Prior Authorization

- Drugs Not on Formulary
- Drugs Not on Formulary Medicaid
- Electroconvulsive Therapy (ECT)
- Hepatitis C Treatment Agents
- Psychological Testing Request

Tip Sheets

- Behavioral Health Tip Sheet
- OB/GYN Tip Sheet
- Primary Care Physician Tip Sheet
- specialist-tip-sheet

Requesting Authorization – Continued

- The forms are designed to streamline the prior authorization and concurrent review process.
  - The forms are fillable PDF files.
  - The forms identify information needed to request services.
  - The goal is to get needed information up front to avoid additional phone calls and free up time for providers.

Prior Authorization/Concurrent Review Forms

- The forms are currently in development for Home and Community Based Services (HCBS), ACT, PROS, PHP/IOP, and Continuing Day Treatment.
- Home and Community Based Services (HCBS)
  - ➢ The form is required for prior authorization.
  - ➢ Concurrent review can be submitted on the form or telephonically.
- Individualized Service Recommendation (ISR) PROS Admission Request
  - ➢ Designed for PROS only.
  - ➢ If authorized, the approval will be for 60 days while provider completes the Individual Recovery Plan (IRP).

Prior Authorization Form

- Prior Authorization Form for Ambulatory Behavioral Health Services
  - Form used to prior authorize ACT, PROS (initial request for Active Rehabilitation), Continuing Day Treatment, and PHP/IOP.
  - Form identifies:
    - Goals and objectives
    - Reason for referral
    - Current level of functioning
    - Psychosocial needs
    - Outcomes of past treatment
    - Rationale for requested treatment level

Concurrent Review Form

- Concurrent Review Form for Ambulatory Behavioral Health Services
  - ➢ Form used to request continued ACT, PROS (Active Rehabilitation), Continuing Day Treatment, and PHP/IOP authorization.
  - ➢ Form identifies:
    - Goal Status
      - ✓Continued, Discontinued, Attained
      - ✓Summary of Progress
    - Any new/revised goals added

Important Information to Consider

- Presenting Problems
    - Demographics, diagnoses, psychosocial needs
- Why is this treatment necessary?
- What else has been tried and why was it not sufficient?
- What prevents the member from being successful at a lower level of care?
- What will be accomplished by this treatment?

Treatment Planning

- Treatment plans, goals, and objectives should be:
  - Simple, Measurable, Achievable, Realistic, and Time Limited.
  - Goals and objectives should be person-centered and recovery-oriented.
  - Treatment plans should provide measurable evidence of progress, or what is changed when progress is not being made.
  - Objectives should specify measureable behavioral changes.
- Discharge planning should begin on day one.

Continuity of Care Rules Specific to BH Services

- For services provided by OMH and OASAS licensed providers, the Select Plan and HARP member can continue receiving services from their BH provider for **Continuous Behavioral Health Episodes of Care for 24 months** from July 2016.
- **Continuous Behavioral Health Episode of Care** means a course of **ambulatory** behavioral health treatment, other than ambulatory detoxification and withdrawal services, which began prior to July 2016, in which services had been provided at least twice during the six months preceding July 2016 by the same provider for the treatment of the same or related behavioral health condition.

Continuity of Care Rules Specific to BH Services – Continued

- CDPHP must accept such providers' treatment plans for Continuous Behavioral Health Episodes of Care and not apply utilization review criteria for a period of **90 days** from July 2016.
- If care is to continue after expiration of the transition period, providers are encouraged to contact CDPHP no later than the beginning of the last month of the transition period to facilitate authorization for continued care.

Questions?