NEW YORK STATE OF OPPORTUNITY. Department of Health | Office of Children and Family Services

Voluntary Foster Care Agencies Medicaid Managed Care Transition

Introduction and Housekeeping

- Slides will be posted at mctac.org and shared after March 21st (conclusion of the last event)
- The Article 29-I manual can be found by clicking here or by going to:

  www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/docs/final_draft_vfca_health_facilities_license_guidelines_5_01_18.pdf
- The Child and Family Treatment and Support Services (CFTSS) manual can be found by clicking here or by going to: https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/docs/updated_spa_manual.pdf

Reminder: ***Information and timelines are current as of the time of the presentation***

Technical Assistance/Support Timeline

Article 29-I Technical Assistance Development:

- Article 29-I Educational Sessions (May 2018)
- Focus Groups with Upstate and Downstate providers (Fall 2018)

Future Article 29-I Technical Assistance Offerings:

- Small group discussions in Buffalo, NYC, Albany, Syracuse, and Westchester (April and May)
- Booster presentations following OCFS spring site visits (May)

Article 29-I Overview

Core Principles, Timeline, Review of Basics, CIN, Staffing and Funding Plan, Cost Reporting

VFCA Core Principles Under Children's Medicaid Redesign and Transition to Managed Care

- Services may be provided by a variety of staff who meet state licensing requirements in accordance with applicable state law
- No loss of access to Medicaid services for children in foster care and families
- Upgrading capacity to care for children placed with VFCAs/higher risk populations through both care management and services
- Article 29-I Licensure and standardized guidelines to deliver services under managed care framework
- Sufficient rate to maintain "Core Limited Health-Related Services" (defined by regulation)
- Time to transition to new models/expectations

Children's Transition Timeline	Scheduled Date
• Implement three of the six new Children and Family Treatment and Support Services (CFTSS) (Other Licensed Practitioner, Psychosocial Rehabilitation, Community Psychiatric Treatment and Supports) in Managed Care and Fee-For-Service	January 1, 2019 **COMPLETED**
• Waiver agencies must obtain the necessary LPHA recommendation for CFTSS that crosswalk from historical waiver services and revise service names in Plan of Care for transitioning waiver children. This is the last billable date of waiver services that crosswalk to CPST and/or PSR.	January 31, 2019 **COMPLETED**
• Transition from Waiver Care Coordination to Health Home Care Management	January 1- March 31, 2019
• 1915(c) Children's Consolidated Waiver is effective and former 1915c Waivers will no longer be active (pending CMS approval)	April 1, 2019

Children's Transition Timeline	Scheduled Date
• Implement Family Peer Support Services as State Plan Service in managed care and fee-for-service • BH services already in managed care for adults 21 and older are available in managed care for individuals 18-20 (e.g. PROS, ACT, etc.) • SSI children begin receiving State Plan behavioral health services in managed care • Three-year phase in of Level of Care (LOC) expansion begins	July 1, 2019
• **1915(c) Children's Consolidated Waiver Services carved-in to managed care** • **Children enrolled in the Children's 1915(c) Waiver are mandatorily enrolled in managed care** • **Voluntary Foster Care Agency Article 29-I per diem and services carved-in to managed care** • **Children residing in a Voluntary Foster Care Agency are mandatorily enrolled in managed care**	**October 1, 2019**
• Implement Youth Peer Support and Training and Crisis Intervention as State Plan services in managed care and fee-for-service	January 1, 2020

Review of the Basics: What is Article 29-I?

Article 29-I licensure authorizes VFCAs to provide the following:

- **Core Limited Health-Related Services**
  - Nursing, Skill Building, and Medicaid Treatment Planning and Discharge Planning, Clinical Consultation and Supervision, Managed Care Liaison/Administrator
- **Other Limited Health-Related Services**
  - Medicaid State Plan services (CFTSS)
  - Medicaid Home and Community Based Services (HCBS) for Children
  - Other Health-Related Services (such as psychiatric, psychological, etc.)

Voluntary Foster Care Agencies (VFCAs) must be licensed for the provision of Limited Health-Related services and bill Medicaid and Medicaid Managed Care Plans to comply with the Corporate Practice of Medicine Standards

Review of the Basics: Focus Group Feedback

In Fall 2018, MCTAC held two focus groups for select upstate and downstate providers. From the focus groups, providers identified 10 areas of concern:

1. Medical Client Identification Numbers (CIN)
2. Cost Reporting/Rate Reconciliation
3. Working with Managed Care
4. Credentialing
5. Phased Implementation
6. Staffing Plan and Funding Plan
7. IT and EHR
8. Encounter-Based Billing; Documentation, and Billing Best Practices
9. Allocations
10. Residual Rate vs. Other Limited Services

Medicaid Client Identification Numbers (CIN)

NYS DOH and OCFS are working through the following:

1. Process to expedite Medicaid eligibility
2. Process to maintain children in the same MCO plan prior to Foster Care placement
3. Process to enroll children in a new MCO plan
4. Managed Care Enrollment: Taking current foster care population currently not in a plan and moving them into a plan
5. Reviewing discharge policies to promote continuity of plan enrollment

Staffing and Funding Plan

- Article 29-I is a standalone program. The application should remain current/reflective of cost reporting
  - What happens if my staffing plan changes?
    - Providers should maintain an updated staffing plan as changes occur

- For example, for changes to staff allocation, if your Article 29-I staffing decreases and it is significant **and intended to be long-term** you should update your staffing plan accordingly in the Article 29-I

The staff ratios found in Article 29-I are guidelines and are based on the level of foster care in which the child is placed. These ratios were used in the development of the residual Medicaid Per Diem Rate, ***but will not be used for purposes of payment audit or to determine compliance with service requirements***

Cost Reporting

- NYS Statewide Standards of Payment (SSOP) will be updated to reflect Core Services. There will be an expectation that all of their Medicaid costs will be reported
- There will be additional cost reporting that goes beyond SSOP. For example, cost reporting for CFTSS will be reported in the Consolidated Fiscal Report (CFR).
- Rate reconciliation is not expected to occur. We currently do not anticipate that the state will take this money back

More information forthcoming

Residual Rate

Overview of VFCA Residual Per Diem Rate Structure

- The Residual Per Diem was designed to reimburse the Core Limited Health-Related Services
- The Residual Per Diem is subject to CMS/State Plan Approval
- There is a **four year transition period** from current rates to Residual Per Diem Rates

Overview of VFCA Residual Per Diem Rate Structure

- The Residual Per Diem will be paid by Managed Care Organizations (MCOs) to VFCA
- The Medicaid costs of the Core Limited Health-Related Services primarily reflect staffing costs
- In addition to the staffing components shown in the table, additional resources for Managed Care Liaisons are included in the Residual Per Diem to facilitate effective communication and coordination with MCOs

Staffing Components
Licensed Behavioral Health Professionals (LBHP)
Nursing Staff
Medicaid Treatment Planning and Discharge Planning
Medicaid Managed Care Liaison/Administration
Clinical Consultation/ Program Supervision

Overview of Residual Per Diem Rate Structure

Level	Description	Facility Type
Level 1	General Treatment	Foster Boarding Home
Level 2	Specialized Treatment	Therapeutic Boarding Home (TBH)/AIDS
		Medically Fragile (Formally Border Babies)
		Special Needs
Level 3	Congregate Care	Maternity
		Group Home (GH)
		Agency Operated Boarding Home (ABH)
		SILP
Level 4	Specialized Congregate Care	Institutional
		Group Residence (GR)
		Diagnostic
		Hard to Place/Raise the Age

- The Residual rate build included the development of staffing assumptions (FTEs and costs) by types of facilities that care for children in foster care today
  - Facility types mirror the VFCA per diem facility classifications that are billed today by VFCAs

Managed Care Capitated Rates and Transition Payments

- The goal of the transition payments is to provide a smooth path that mitigates swings in cash flow during the initial years of the transition to Managed Care
  - The MCOs will pay *at least* the Residual Per Diem government rates for the transition period
  - The transition period will be for ***four years***
  - The Residual Per Diem government rates will reflect VFCAs transition rates from current VFCA Per Diem to Residual Per Diem
  - Following the four year period, MCOs will negotiate the rates with VFCAs. VFCAs will be at risk for per unit cost and utilization

Article 29-I Core Limited Health-Related Services

- There are **5** Core Limited Health-Related Services:
  - Nursing
  - Skill-Building
  - Medicaid treatment Planning and Discharge Planning
  - Clinical Consultation and Program Supervision
  - VFCA Managed Care Liaison Services/Administration
- VFCAs **must** provide, or make available through a contract arrangement, all Core Limited Health-Related Services
- The Core Limited Health-Related Services apply **only** to children/youth in the care of a VFCA
- The rates for Core Limited Health-Related Services are determined by NYS
- Billing Guidance forthcoming

18

Article 29-I Core Limited Health-Related Services (Continued)

- The intent of Article 29-I is to allow providers to work in the milieu without having to account for every 15 minutes of their time
- The 5 VFCA Core Limited Health-Related Services play a vital role in assuring the following:
  - All necessary health-related services are provided in the specified time frames
  - The child's parents and caregivers are involved in the planning and support of the child's treatment (as applicable)
  - Information is shared appropriately among professionals involved in the child's care
  - All health-related information and documentation results in the culmination and implementation of the ***Comprehensive Individualized Person-Centered Treatment Plan***

Article 29-I Other Limited Health-Related Services

- VFCAs **may also provide** Other Limited Health-Related Services that are consistent with treatment plan and include screening, diagnosis and treatment related to physical health and behavioral health
- If the agency chooses to provide these services, they need to contract with Medicaid Managed Care
- To provide Other Limited Health-Related services, VFCAs must posses all required NYS certifications, designations and/or license.
- These services may be provided post Foster Care

Article 29-I Other Limited Health-Related Services (continued)

Other Limited Health-Related Services Include:

- ✓ Medicaid HCBS for Children
- ✓ Medicaid State Plan Services
  - Screening, diagnosis, and treatment services related to **physical health**
  - Screening, diagnosis, and treatment services related to **developmental and behavioral health**
  - Children and Family Treatment and Support Services (CFTSS)

Other Limited Health-Related Services do NOT include surgical services, dental services, orthodontic care, and general hospital services including emergency care, birth center services, emergency intervention for major trauma, treatment of life-threatening or potentially disabling conditions.

Article 29-I Other Limited Health-Related Services: Medicaid HCBS for Children

- Caregiver Family Support and Services
- Community Self Advocacy Training and Support
- Respite
- Prevocational Services
- Supported Employment
- Palliative Care
- Community Habilitation
- Day Habilitation

Please note: HCBS are standalone services - there is no overlap between these services and the Core Limited Health-Related Services

Other Limited Health-Related Services: Medicaid State Plan Services

Screening, diagnosis, and treatment services related to physical health may include:

- Ongoing treatment of chronic conditions as specified in the treatment plans
- Diagnosis and treatment related to episodic care for minor ailments, illness, or injuries, including sick visits
- Primary pediatric/adolescent care
- Immunizations in accordance with the current NYS or NYC recommended childhood immunization schedule, as appropriate Immunizations
- Reproductive health care

Screening, diagnosis, and treatment services related to developmental and behavioral health may include:

- Psychiatric consultation, assessment, and treatment
- Psychotropic medication treatment
- Developmental screening, testing, and treatment
- Psychological screening, testing, and treatment
- Smoking cessation treatment
- Alcohol and/or drug screening and treatment
- **Child and Family Treatment and Support Services (CFTSS)**
    - OLP, PSR, CPST, FPSS, YPST, Crisis Intervention

Other Limited Health-Related Services: Rates

Rates that are negotiated with Managed Care Organizations (MCOs)*	Rates that are set by NYS
● Screening, diagnosis, and treatment related to *physical health* ● Screening, diagnosis, and treatment related to developmental and behavioral health for the following services: ○ Psychiatric consultation, assessment and treatment ○ Developmental screening, testing and treatment ○ Psychotropic Medication Treatment ○ Psychological screening, testing and treatment ○ Alcohol and/or drug screening and intervention ○ Smoking cessation treatment	● Medicaid HCBS for Children ● Screening, diagnosis, and treatment related to developmental and behavioral health for the following services (CFTSS): ○ Other Licensed Practitioner (OLP) ○ Psychosocial Rehabilitation (PSR) ○ Community and Psychiatric Support and Treatment (CPST) ○ Family Peer Support Services (FPSS) ○ Youth Peer Support and Training (YPST) ○ Crisis Intervention

*There are ongoing discussions for potential state involvement in rate determination

Article 29-I Skill Building

Who can provide?

Skill Building is provided by **licensed behavioral health practitioners** (LBHPs) including

- Psychoanalysts
- Clinical Social Workers
- Marriage and Family Therapists
- Mental Health Counselors
- Master Social Workers

- *LCATs are pending

What can they do?

Article 29-I Skill Building activities may include:

- Establishing treatment goals
- Providing individual counseling and treatment, substance abuse counseling and treatment, family and group counseling, transitional counseling
- Promoting psycho-education and wellness education
- Others as listed in Article 29-I

Note: In addition to the skill building activities listed in Article 29-I, LBHPs are able to operate within their scope of practice

Potential Areas of Overlap		Article 29-I Other Limited Health-Related Services
		CFTSS
Article 29-I Core Limited Health-Related Services (Residual Per Diem)	Skill Building via LBHP	• **Psychosocial Rehabilitation** (PSR) • **Other Licensed Practitioner** (OLP) • **Community Psychiatric Supports and Treatment** (CPST)

Article 29-I Clinical Consultation and Program Supervision

Who can provide?

Clinical Consultants and Program Supervisors provide oversight and supervision within their scope of practice to Nursing and LBHP. They include:

- Physicians
- Psychiatrists
- Psychologists
- Nurse Practitioners
- Psychoanalysts
- Registered Nurses
- Clinical Nurse Specialists
- Clinical Social Worker
- Marriage and Family Therapist
- Mental Health Counselor
- *LCATs are pending

What can they do?

Article 29-I Clinical Consultant and Supervisor activities may include:

- Reviewing all healthcare information and medical records
- Medical eligibility recommendations for foster care rates pertaining to healthcare conditions
- Meeting and communicating with biological families, guardians, foster families, and caseworkers
- Quality oversight and improvement services
- Others as listed in Article 29-I

Note: In addition to the activities listed in Article 29-I, Clinical Consultants/Program Supervisors are able to operate within their scope of practice

Potential Areas of Overlap		Article 29-I Other Limited Health-Related Services	
		Physical Health	**Developmental and Behavioral Health**
Article 29-I Core Limited Health-Related Services (Residual Per Diem)	**Clinical Consultation and Program Supervision** (under the scope of practice)	• Ongoing treatment of chronic conditions as specified in treatment plans • Immunizations in accordance with the current NYS or NYC recommended childhood immunization schedule, as appropriate Immunizations • Diagnosis and treatment related to episodic care for minor ailments, illness or injuries, including sick visits • Reproductive health care • Primary pediatric/adolescent care	• Psychiatric consultation, assessment and treatment • Developmental screening, testing and treatment • Psychotropic Medication Treatment • Psychological screening, testing and treatment • Alcohol and/or drug screening and intervention • Smoking cessation treatment

There is no overlap between Article 29-I's Nursing Services, Medicaid Treatment Planning and Discharge Planning, and VFCA Managed Care Liaison/Administrator (Core Limited Health-Related Services) and Article 29-I's Other Limited Health-Related Services

Who can receive these services?

Any eligible child who is **currently placed** with a VFCA is able to receive **Core Limited Health-Related Services, Other Limited Health-Related Services, CFTSS, and HCBS** from that VFCA as long as:

- The VFCA has an Article 29-I license to provide Core Limited Health-Related Services, and;
- Is designated to provide CFTSS or HCBS services, and;
- The child is Medicaid eligible AND the child meets medical necessity for CFTSS or meets HCBS criteria and;
- Is contracted with Managed Care to deliver Core Limited Health-Related Services and Other Limited Health-Related Services for children in MCOs

Who can receive these services (continued)?

Any child who is **currently not placed** with your VFCA can receive **Other Limited Health-Related Services, inclusive of CFTSS and HCBS,** from your VFCA under the following circumstances:

- **Post final discharge from foster care:** CFTSS and/or HCBS can be provided to support continuity of care with no timeline
- **Post final discharge from foster care**: Other-Limited Health-Related Services specific to physician, psychiatrist, psychologist etc. can be provided for one year
- A VFCA provider can provide CFTSS and Other Limited Health-Related Services to any child placed in another VFCA *that is not already providing these services at the time* or children in the direct placement of a Local Department of Social Services

31

What if I have a staff member who can provide services under MSAR, CFTSS (Other Limited Health-Related Services), and Core Limited Health-Related Services?

VS.

NEW YORK STATE OF OPPORTUNITY. Department of Health | Office of Children and Family Services

Considerations/Impact

- **Ratios:** Staff to children ratios should be one of the major factors driving your decisions on whether you bring on new staff to provide CFTSS and Other Limited Health-Related Services or to share existing staff between multiple programs
- **Financial Feasibility:** Deciding what level staff to provide particular services based on qualifications and requirements
- **Impact on future MSARs:** If you choose to share staff between MSAR and Article 29-I and/or CFTSS, consider future rate implications for MSAR
- **Engagement and Relationship:** During the transition period, consider staff who are already engaged with the particular client to continue with that client or have an appropriate transition to other staff
- **Nimble/Change over time:** Be prepared to change your approach as needed. For example, while you're looking for new staff, some of your existing staff can provide services on a limited basis until transitioning to new staff
- **Staffing:** Ability to recruit, hire, and retain staff
- **Documentation:** Expectations of Medicaid level of documentation for CFTSS and for Other Limited-Health Related Services

Scenario 1:
Allocating between MSAR and CFTSS

- Consider a childcare worker funded out of MSAR who might also provide Psychosocial Rehabilitation (PSR) under CFTSS.
- **There are a few ways to address this issue:**
  - Have two staff members perform two separate functions. Use multiple FTEs to fulfill this function and have some of their time allocated to providing PSR
  - Use the same individual to fulfill both functions by adding additional hours to be able to allow for the second function to be completed. For example, a staff member increasing their hours from 35 hours to 40 hours where the extra 5 hours are allocated to PSR
  - Use the same individual to fulfill both functions. For example, half of their time (.5 FTE) to provide MSAR services, and half of their time (.5 FTE) to provide PSR

Scenario 2: Supplementing Article 29-I Skill Building with CFTSS

- The Article 29-I Core Limited Health-Related Service: Skill Building primarily creates and monitors treatment plans. The Skill Builder may also provide services within their scope of practice.
- **Issue:** The Skill Building staffing ratio for children Level 1 – Foster Boarding Home is **1:117.** Staff managing this ratio would have insufficient time to perform other services
- **There are a few ways to address this issue:**
  - Have **one** FTE overseeing 117 individuals under Skill Building and have other staff provide services under Other Limited Health-Related Services (OLP and/or CPST)
  - Use multiple FTEs to fulfill this function, and have some of their time allocated to providing Other Limited Health-Related Services (OLP and/or CPST)
  - **When your program has less children than the staffing ratio recommends:** If, for example, your program has 58 children, you only need .5 FTE to meet the staffing ratio. You might consider using the other .5 FTE to provide Other Limited Health-Related Services (OLP and/or CPST)

Scenario 3: Supplementing Clinical Consultation and Program Supervision with Other Limited Health-Related Services

- The Article 29-I Core Limited Health-Related Service: Clinical Consultation and Program Supervision role provides oversight and supervision within their scope of practice to Nursing and LBHP staff
- **Issue:** The Clinical Consultation and Program Supervision staffing ratio for children Level 1 – Foster Boarding Home is **1:310.** Staff managing this ratio would have insufficient time to perform other services
- **There are a few ways to address this issue:**
  - Have **one** FTE oversee 310 individuals under Clinical Consultation and Program Supervision and have other staff provide services under Other Limited Health-Related Services (not CFTSS or Medicaid HCBS for Children)
  - Use **multiple** FTEs to fulfill this function and have some of their time allocated to providing services
  - **When your program has less children than the staffing ratio recommends:** If, for example, your program has 155 children, you only need .5 FTE to meet the staffing ratio for the Clinical Consultation and Program Supervision service. Consider using the other .5 FTE to provide Other Limited Health-Related services (not CFTSS or Medicaid HCBS for Children)

Scenario 4: Core Limited Health-Related Services with Low Staffing Ratios

- The Article 29-I manual states that certain Core Limited Health-Related Services have low staffing ratio recommendations due to the intensive care needed within a specific population
- In these cases, it is likely that the provider will be able to deliver Core Limited Health-Related Services instead of using Other Limited Health-Related Services
- However, when appropriate and needed, CFTSS can be utilized as long as staffing ratios are aligned appropriately and the individual is getting the necessary services
- **Core Limited Health-Related Service: Skill Building Example**
  - The Skill Building staffing ratio for Level 4 – Specialized Congregate Care: Hard to Place is **1:12.** In this scenario, it is likely that the provider meets the needs of youth under the Core Limited Health-Related Services instead of using Other Limited Health-Related Services (OLP and/or CPST)

Scenario 5 & 6 : Providing CFTSS Only

- **Scenario 5:** VFCAs can provide CFTSS to children post final discharge as long as the services would not be duplicated.

- **Scenario 6:** The VFCA can provide CFTSS to a child who is placed with another VFCA as long as the services would not be duplicated

Scenario 7: Staff Allocation

- Staff who provide services under Core Limited Health-Related Services and Other Limited Health-Related Services needs to be appropriately allocated
- **For example:**
  - A full time (35 hours per week) staff member provides 21 hours of Core Limited Health-Related Services and 14 hours of CFTSS under Other Limited Health-Related Services
  - The staffing plan should therefore reflect that:
    - 60% of their time is allocated to providing Core Limited Health-Related Services
    - 40% of their time is allocated to providing CFTSS under Other Limited Health-Related Services

Scenario 8: Reallocating Staff Time

- When deciding between providers who deliver Core Limited Health-Related Services and Other Limited Health-Related Services, VFCAs can use the suggested Article 29-I Core Limited Health-Related Services staffing ratios to guide their staffing plan
- If the staffing plan set out by the VFCA is not met, the VFCA must either reallocate staff **or** update the staffing plan in a timely fashion to reflect the changes
- **For example:**
  - If the VFCA decides to reallocate a FTE's time so that 20% of their time is dedicated to providing Other-Limited Health Related Services, the VFCA must either:
    - Have another appropriately qualified staff member provide Core Limited Health-Related Services that replaces the reallocated time (20% in this example)
    - Update the staffing plan to reflect that for one FTE LBHP, 80% of their time is spent providing Core Limited Health-Related Services and 20% of their time is spent providing Other Limited Health-Related Services

Scenario: 9
Allocating between MSAR, Core Limited Health-Related Services, and Other Limited Health-Related Services

- Consider a childcare worker funded out of MSAR who might provide CFTSS Psychosocial Rehabilitation (PSR) and Article 29-I Medical Escort
- **There are a few ways to address this issue:**
  - Have three staff members perform three separate functions. Use multiple FTEs to fulfill this function and have some of their time allocated to providing CFTSS PSR and Article 29-I Medical Escort
  - Use the same individual to fulfill all functions with adding additional hours to be able to allow for the second function to be completed. For example, having a staff member going from 35 hours to 40 hours where the extra 5 hours are allocated to CFTSS PSR and Article 29-I Medical Escort
  - Use the same individual to fulfill all functions. For example, 40% of a staff member's time is dedicated to MSAR, 40% is dedicated to CFTSS PSR, and 20% is dedicated to Article 29-I Medical Escort

Allocations

Staff Allocation Principles

- Staff can be allocated between Core Limited Health-Related Services, Other Limited Health-Related Services (including CFTSS and Medicaid HCBS for Children), and/or Foster Care Room and Board ***as long as*** their time is allocated appropriately and expensed appropriately
- All staff allocations should always equal 100%, even for part-time staff.
- Allocations should represent how staff's time is spent and is consistent with what is described in their job description

Staffing Tips

- **Partnering with other agencies:** In cases where your VFCA cannot provide particular services, VFCAs can reach out to other VFCAs in the region to:
  - Partner in hiring staff together
- **Licensure/credentialing requirements:** For services that do not require licensure or a higher level credential, consider hiring appropriately credentialed staff that meets those requirements
  - This may help with costs and the VFCA's ability to hire staff

Allocations

- It’s not just billable time. Allocations go beyond billing such as documentation, case management, meetings, etc.
- Including other expenses such as fringe, space, travel, etc.

An Important Reminder…

- Staff can be allocated between Core Limited Health-Related Services, Other Limited Health-Related Services (including Medicaid HCBS for Children and CFTSS), Foster Care Room and Board Services, and other State Plan Services as long as their time is allocated, billed, and expensed appropriately
- Agencies **may not** separately bill for activities performed by staff when all or a part of the Full Time Equivalent (FTE) for that position is funded within the Medicaid Per Diem Rate
- To the extent that all or part of the salary for a practitioner for one of these Core Limited Health-Related services or administration are included in the Medicaid Per Diem Rate, the agency **may not** bill separately for activities for the portion of the salary included for that professional
- For allocated staff, be mindful of staffing ratios requirements across all the programs in which they are allocated

Bottom line: You cannot bill for the same person's time twice

Preparing to work with Managed Care

Working with Managed Care: Managed Care Definition

- An integrated system that **manages health services** for an enrolled population rather than simply providing or paying for the services
- Services are usually delivered by providers who are contracted under a capitated payment structure or employed by the plan
- Value/medical necessity of services vs. volume of services

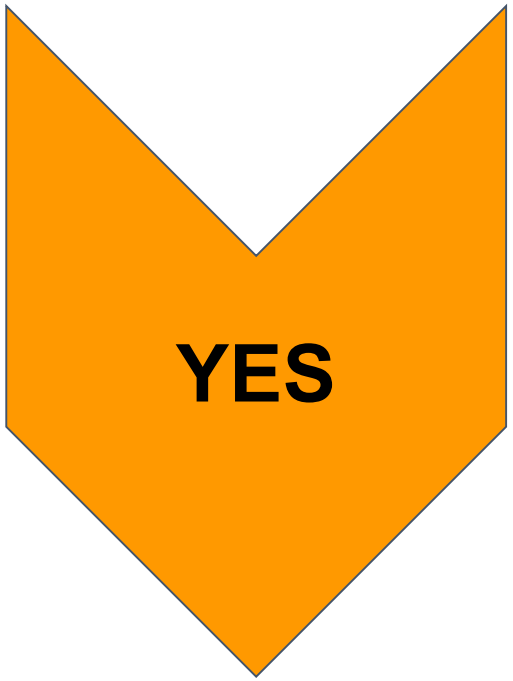
Working with Managed Care: Managed Care Goals

- **Control Costs**
  - Reduce inappropriate use of services
  - Increase appropriate use of services
  - Focus on value and medical necessity
- **Improve Service Quality**
- **Improve Population Health**
- **Increase use of Preventative Healthcare/Promote Health** (not just treat illness)

Working with Managed Care:
Managed Care Key Ingredients

- Care Management
- Utilization Management
- Network Development and Management
- Credentialing
- Vertical and Horizontal Service Integration and Coordination
- Financial Risk Management

Working with Managed Care: Determining Service Provision and Payment



- Member?
- Service Included?
- Medically Necessary?
- Authorization?
- MCO Network?

The answers to all of the above questions must be "yes" if the service is to be paid by the MCO

Tips on Negotiating Rates for Other Limited Health-Related Services

- Determine your unit costs
- Determine volume
- Assess your landscape to determine who else is providing services in your area
- Make a solid case as to why MCOs should contract with you/value proposition
- Consider other options for payment such as incentive, pay for performance, or case rates

Rates that are negotiated with Managed Care Organizations (MCOs)*

- Screening, diagnosis, and treatment related to *physical health*
- Screening, diagnosis, and treatment related to developmental and behavioral health for the following services:
  - Psychiatric consultation, assessment and treatment
  - Developmental screening, testing and treatment
  - Psychotropic Medication Treatment
  - Psychological screening, testing and treatment
  - Alcohol and/or drug screening and intervention
  - Smoking cessation treatment

*There are ongoing discussions for potential state involvement in rates

Credentialing

Credentialing

- When credentialing, the MCO shall accept state licenses/designations, operation and certifications in place of, and not in addition to, any MCO requirements
- MCOs can still collect and accept agency/program level credentialing related information
- Based on state directives, MCOs may not be credentialing individual practitioners. However, they might request a roster of an organization's staff
- MCOs shall require that such providers not employ or contract with any employee, subcontractor, or agent who has been suspended by the federal or state government, or otherwise excluded from participation in the Medicare or Medicaid program

Tips for Credentialing

- Agencies are required to ensure that the services are provided by appropriately credentialed staff based on state requirements
- Since MCOs may not be credentialing individual practitioners, agencies **must** maintain accurate and up to date credentials of individual staff *(as a reminder, credentials need to be updated)*

Phased Implementation

Phased Implementation: Other-Limited Services and CFTSS

Agencies should consider phasing in Other Limited Health-Related Services and CFTSS by considering the following approaches;

- Increasing working hours of current staff to provide these services
  - For example, a FTE staff working 35 hours could be offered 5 additional paid hours to provide these services or a staff's time could be split between core residual and CFTSS, scope of practice depending
- Utilizing per diem/fee for service staff to deliver these services

Phased Implementation (continued)

Infrastructure:

- **Billing**: Agencies that currently have limited or no billing capacity can consider utilizing vendors to meet billing needs
- **HR/Credentialing and Finance**: Consider subcontracting for financial services
- **Utilization Review/Utilization Management**: Consider using per diem or fee for service staff or subcontracting with other providers to use their staff

Electronic Health Record (EHR)

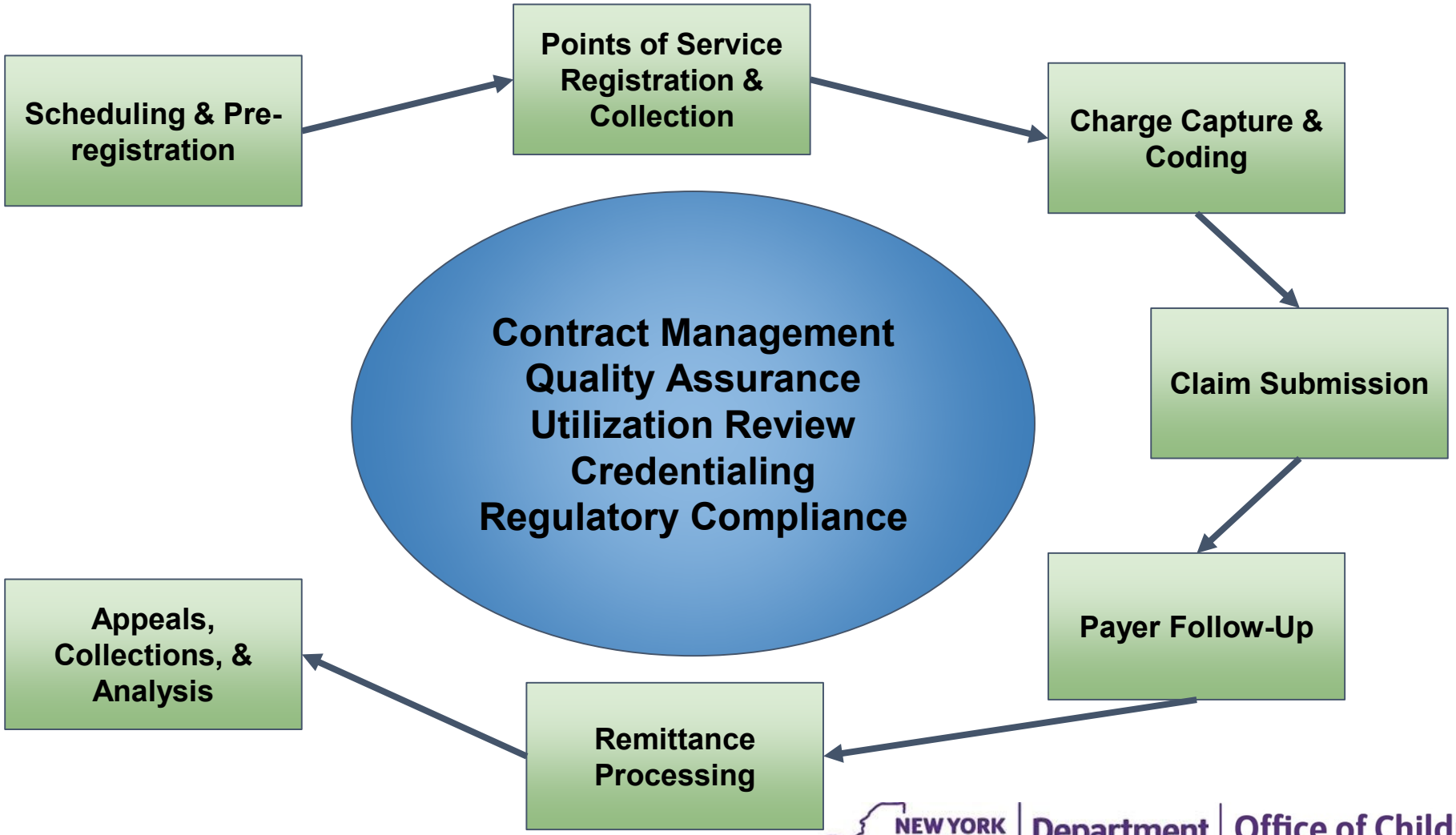
Information Technology

- Are your IT, not just EHR, systems adequate?
- Do you have a strategy for billing?
- Are you HIPAA compliant?
- Do you have an EHR and is it set up for new services?

Electronic Health Record

- Flexible
- Responsive to agency needs
- Ability to connect finance and clinical data
- Ability to handle data from multiple platforms
- Able to generate needed reports and monitor quality and outcomes

Billing Best Practices



NEW YORK STATE OF OPPORTUNITY. Department of Health | Office of Children and Family Services

EHR: Tools to Support Revenue Cycle Management (RCM)

A full featured properly implemented EHR/EMR with a strong billing component can bring significant efficiencies and accuracy to the revenue cycle process by:

- Providing electronic scheduling to maximize the use of provider capacity
- Efficiently evaluating insurance eligibility
- Tracking authorizations and alerting staff when they are approaching thresholds
- Providing behind the scenes management of charge capture and coding to eliminate errors, maximize revenue, and minimize audit risk

ePaces

Q: What is ePaces?

A: ePACES is the acronym for the Electronic Provider Assisted Claim Entry System, a web-based application which will allow Providers to create/submit claims and other transactions in HIPAA format. eMedNY developed this application on behalf of the NYS Department of Health.

Q: How do I enroll in ePaces?

A: ePACES Enrollment begins with issuance of a token and then responding to a series of emails generated by accessing the website https://www.emedny.org/enroll/. Call 800-343-9000 to obtain a token.

Q: How long does it take to enroll in ePaces?

A: The enrollment time frame is based on the provider's response time to multiple emails delivered through the enrollment process.

EHR: Some Options:

Short of a fully functional EMR/EHR, for a strong Revenue Cycle Management system, other options include:

- Outsourcing billing services
- Using Clearinghouse services
- Making sure in-house or standalone billing systems are available
- Using a combination of in-house billing systems (either EMR/EHR or standalone based) and a clearinghouse claims processor

EHR: Tools to Support RCM

- Catch and suspend claims that do not meet payer and documentation requirements to minimize audit risk
- Efficiently post payments to maintain accurate client accounts
- Provide reports necessary to address staff, system, and payer performance issues

MCO Tips for Successful RCM

- Develop a good relationship with your clearinghouse vendor
- Review HIPAA requirements for electronic claim submissions
- Review and respond to clearinghouse reports (i.e. acceptance and denials)
- Promptly make corrections and submit the claim(s) to clearinghouse
- Review and respond to payer provider remittance advices to allow time to make corrections and appeals

MCO Tips for Successful RCM

- Remember timely filing deadlines
- Review and update claim form and make adjustments to ensure correct information is in each field to avoid delay/denial of payment with managed care payers
- Be mindful that claims forms often have pre-populated fields which worked for FFS but won't work with MCOs
- Sign up for Electronic Payments and Statements for each payer
- If the individual practitioner is Medicaid enrollable they must enroll and use NPI number on claims.
- If the individual practitioner is not enrollable and does not have an NPI number the OMH (02249154), OASAS (02249145), or OCFS (05448682) unlicensed practitioner ID may be used. If individual practitioner is not enrollable and does have an NPI, agency may choose to use that NPI.

Encounter-Based Billing: Documentation and Billing Best Practices

Documentation

- Documentation is one of the most important components of rendering services
- Behavioral health documentation for services must meet specific requirements for Medicaid reimbursement to include:
  - Meet that State's Medicaid program rules
  - Reflect medical necessity and justify the treatment and clinical rationale (each State adopts its own medical necessity definition)
  - Reflect active treatment
  - Be complete, concise, and accurate, including the face-to-face time spent with the patient (for example, the time spent to complete a psycho-social assessment, a treatment plan, or a discharge plan);
  - Be legible, signed, and dated
  - Be maintained and available for review
  - Be coded correctly for billing purposes

Medical Necessity

Documentation of medical necessity must include how the Core Limited Health-Related services are intended to address **any** of the following:

1. Deliver **preventive supports** through an array of clinical and related activities including psychiatric supports, information exchange with Medicaid community and skill-building.
2. **Reduce the severity** of the health issue that was identified as the reason for admission.
3. **Provide targeted treatment** related directly to the child's ability to function successfully in the home and school environment (e.g., compliance with reasonable behavioral expectations; safe behavior and appropriate responses to social cues and conflicts or medically appropriate care).

Treatment Plan

- The VFCA is responsible for coordinating and confirming the completion of comprehensive health assessments and services
- Using results & recommendations of required assessments, the Comprehensive Individualized Person-Centered Treatment Plan is developed within 30 days, reviewed and re-evaluated annually, and must
    - Include a person-centered, individual directed approach to the development & implementation
    - Include active participation of the child, family and service providers
    - Contain the treatment plan goals from the individual health assessments including:
        - Type of services needed to achieve identified treatment goals
        - Service intensity
        - Progress indicators
        - Clear action steps and target dates
        - Measurable discharge goals

Treatment Plan (continued)

- **(continued)** Using results & recommendations of required assessments, the Comprehensive Individualized Person-Centered Treatment Plan is developed within 30 days, reviewed and re-evaluated annually, and must
  - Utilize the Core Limited Health-Related services and the required Clinical Consultation/Supervision and any administrative functions to provide activities that are intended to achieve goals or objectives
  - Be based on the child's conditions and include Specific problems, Needs, Preferences & Strengths
  - Be re-evaluated annually or as needed, to determine whether services have contributed to meeting goals
  - Include emergency protocols specific to the child, as appropriate.

The Golden Thread

The Golden Thread is the consistent presentation of relevant clinical information throughout all documentation for a client

Each piece of documentation should flow logically from one to another such that the presenting problems, contributing/mitigating factors (strengths) and intervention strategies are all aligned to address the noted concerns

Preparing for Day 1

Preparing for Day 1

- **Innovate/Adapt:** Consider how your work might need to change order to support the outcomes required in the transformed system
- **Build Relationships with MCOs and other partners**
- **Building a Team:** Inclusive of members across departments that focuses on preparing for and implementation of health care reform
- **Training:** Think about the training you will need in order to be successful in this new model - and share your thoughts with your supervisor
- **Get Involved:** Participate in relevant trainings/agency planning sessions

Preparing for Day 1 (continued)

Before day 1:

- Ensure that there are contracts with Managed Care Organizations, or at the very least single case agreements, that children are enrolled in
- Inventory Check:
  - Who are your staff, what are their credentials, and what services can they provide?
  - Create job descriptions. This can be used as a reference and will also help align your communications with HR
  - Are your policies and procedures updated to be in compliance with Article 29-I?

Minimal requirements for day 1

- Establishing medical necessity to bill the Residual Rate
- Create treatment plans 30 days (from October 1st) and 30 days for new admissions

Preparing for Day 1 (cont)

Do you have a strategic plan?

- Do you have a process for transitioning existing children?
- Do you have a process for children who are discharged from foster care during this transition period?
  - CFTSS services as a way to enhance services to children and families, and as a continuation as a business opportunity
- Have you communicated with the community and other providers?
- Have you communicated with managed care for members you are already serving?
  - Is there communication with the managed care plan on a child specific basis?
  - LDSS
- Have you worked out staffing, caseloads, process to ensure timely service delivery?

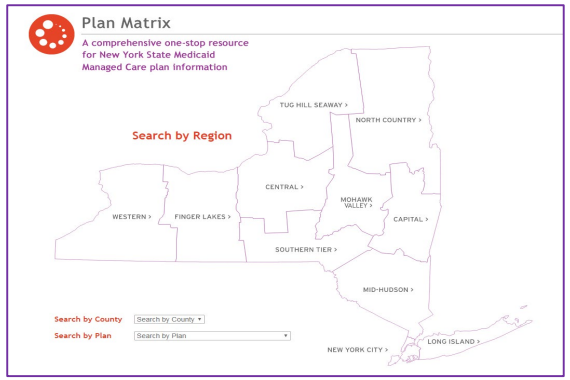
Preparing for Day 1 (cont)

- You might not have enough staff to provide Other Limited Health-Related Services (such as CFTSS) in time for Day 1
- In cases where Core Limited Health-Related Services potentially overlaps with Other Limited Health-Related services, such as Skill Building and OLP & PSR, it is okay to initially incorporate all services under the Core Limited Health-Related Services
    - As time goes on, you can continually increase or reallocate your staff to allow for Other Limited Health-Related services to be provided

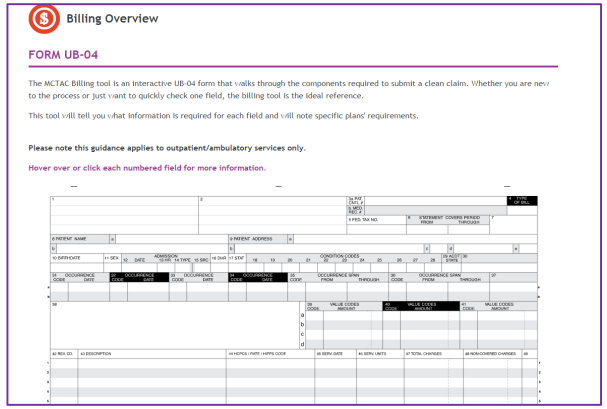
Resources

Tools

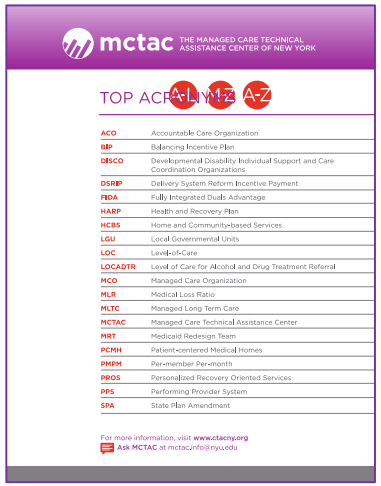
Select the Tools Tab at www.mctac.org



Managed Care Plan Matrix – comprehensive resource for MCO contact information relevant to adults and children. https://matrix.ctacny.org/



Billing Tool – Children System specific updates. https://billing.ctacny.org/



Glossary of Terms- Interactive online glossary of frequently used managed care terminology. Includes a printable top acronyms "cheat sheet." https://glossary.ctacny.org/

Resources to Keep Informed

DOH website:

https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/web-info_child_mst.htm

DOH Transition Mail Log

BH.Transition@health.ny.gov

Article 29-I Manual

www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/docs/final_draft_vfca_health_facilities_license_guidelines_5_01_18.pdf

CFTSS Manual

https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/docs/updated_spa_manual.pdf

Emedny (NYS Medicaid Eligibility Verification Systems Methods

https://www.emedny.org/ProviderManuals/5010/MEVS%20Quick%20Reference%20Guides/5010_MEVS_Methods.pdf