Introduction & Housekeeping

• 1st webinar in series about UM and Billing. In-person meetings will follow, please visit mctac.org to sign up.

• Housekeeping
  • WebEx Chat Functionality for Q&A
  • Slides are posted at MCTAC.org and a recording will be available soon (usually less than one week)
  • Questions not addressed today will be re-visited during subsequent presentations

• Reminder: Information and timelines are current as of the date of the presentation.
What is MCTAC?

MCTAC is a training, consultation, and educational resource center that offers resources to *all mental health and substance use disorder providers in New York State*.

**MCTAC’s Goal**
Provide training and intensive support on quality improvement strategies, including business, organizational and clinical practices to achieve the overall goal of preparing and assisting providers with the transition to Medicaid Managed Care.
Who is MCTAC?
MCTAC Partners
Learning Objectives

• Understand the services to be covered by Managed Care

• Understand the purpose of Utilization Management

• Learn about the upcoming in-person Billing and UM training programs and the topics to be covered

• Reminder of key policy to support BH transition to Managed Care with an emphasis on: claiming and reimbursement policy
Utilization Management Overview

March 2016
Overview

• Transforming the System

• Minimize disruptions for current clients
  • No authorizations required for first 90 days
  • Can continue with current provider for 2 years, even if provider is out of network

• Promote access to outpatient services

• Promote evidence based care
  • Encourage plans and providers to dialog about approaches
  • Encourage plans to develop innovative strategies to care management
What are the Services Transitioning to Managed Care?
OMH Program/Services that are transitioning to Managed Care

- Inpatient psychiatric services in Article 28 facilities
- Part 599 clinic services
- Behavioral health services in Part 598 integrated clinics
- Personalized Recovery Oriented Services (PROS) programs operated under Part 512
- Continuing Day Treatment (CDT) programs operated under Part 587
- Intensive Psychiatric Rehabilitation Treatment (IPRT) programs operated under Part 587
- Assertive Community Treatment (ACT) programs operated under Part 508
- Partial Hospitalization (PH) programs operated under Part 587
- Inpatient Psychiatric Hospitalization Services operated under Parts 580 or 582
- Comprehensive Psychiatric Emergency Programs (CPEPs) operated under Part 590
- Crisis Intervention
- Behavioral Health Home and Community Based Services (BHHCBS): available to eligible Health and Recovery Plan (HARP) and HARP-eligible HIV Special Needs Plan (SNP) enrollees only
OASAS Program/Services that are transitioning to Managed Care

• OASAS Clinic
• OASAS Opioid Treatment Program
• OASAS Outpatient Rehab
What is Utilization Management?
What is Utilization Management?

• The process by which an MCO decides whether specific health care services, or specific level of care, are appropriate for coverage (to be paid) under an enrollee’s plan
• Primary purpose of the program is to ensure that services are necessary, appropriate, cost-effective, and at the least restrictive level of care
• Utilization Review (UR) vs. Utilization Management (UM)
  ▪ UR – Regulatory requirement, Internal review.
  ▪ UM – MCO standards, External review
Why Do MCOs Conduct Utilization Management?

• Managed Care is an integrated system that manages health services for an enrolled population rather than simply providing or paying for the services (outcomes, service quality and service expenditures).
• Generally MCOs are paid for health benefits administration on a capitated basis (A fixed amount for each member each month/Per Member Per Month -PMPM).
• The MCO’s role is to make sure the individual receives the least restrictive care they require while staying within the dollars available for that year.
• The core function of the UM program is to ensure that the MCO pays for only those services that are “medically necessary.”
• Involves a determination of whether the service is necessary and appropriate for the patient’s symptoms, diagnosis, and treatment and recovery. Also reviews for the appropriate length of care.
• UM applies chiefly to diagnostic and evaluative services, hospital services, and certain specialty services including HCBS; primary care services are not typically subject to prior authorization or concurrent review.
What does it mean to be Medically Necessary?

• Involves a determination of whether the service is necessary and appropriate for the patient’s symptoms, diagnosis, treatment, and recovery.

• Many MCO contract definitions of “medically necessary” state that services may not be provided primarily for the convenience of the patient or the provider.

• **New York State Department of Health** requires the following definition of Medically Necessary:
  Medically necessary means health care and services that are necessary to prevent, diagnose, manage or treat conditions in the person that cause acute suffering, endanger life, result in illness or infirmity, interfere with such person’s capacity for normal activity, or threaten some significant handicap.
State Utilization Management Guidance

Utilization management for ambulatory behavioral health (BH) services that will be effective when the MCOs, including MMCPs, HARP, and HIV SNPs assume management of these services in the adult Medicaid Managed Care Program:

- Services include routine outpatient office and clinic care as well as the full range of BH specialty services.
- MCOs will not use prior authorization for Medicaid BH outpatient office and clinic services as of the implementation of the behavioral health carve-in.
- MCO responses to the RFQ indicated the intent to minimize use of prior authorization for routine BH outpatient office and clinic services as it has proven an inefficient form of utilization management.
- Parity requirements prohibit the imposition of non-quantitative treatment limits or benefit exclusions based on medical necessity or medical appropriateness when there are no such limits for similar medical/surgical services.
Types of Reviews?

*Prior Authorization Request* is a Service Authorization Request by the enrollee, or a provider on the enrollee’s behalf, for coverage of a new service, whether for a new authorization period or within an existing authorization period, made before such service is provided to the enrollee.

*Concurrent Review Request* is a Service Authorization Request by an enrollee, or a provider on Enrollee’s behalf for continued, extended or additional authorized services beyond what is currently authorized by the Contractor within an existing authorization period.
Typical Utilization Management Process

1. **Prior to calling the MCO**
   - Review Level of Care (LOC) criteria for the service being requested/discussed
   - Review the specific information regarding the individual (presenting problem, current symptoms, medications, recent treatment) and formulate a rationale for the requested LOC and anticipated service units

2. **Contact the MCO representative**
   - Provide patient name, Date of Birth (DOB), Medicaid number (CIN) and your name, facility name and contact number
   - Identify the start date for treatment being requested
   - Request the services and number of service units (days, visits, etc.) necessary to deliver these services
   - Present rationale for request
3. **Discuss planned treatment changes (if any) and anticipated service units**

4. **Always include overview of the long term treatment/support plan (including discharge planning steps if the individual is in an inpatient setting)**
   - Communication with treatment providers (new, existing)
   - Family meetings
   - Medications (new, existing, changes)
   - Patient involvement (person centered approach)
   - If inpatient, discharge plans: to home, HWH, transfer to another facility, etc..

5. **Obtain decision from MCO, document and schedule next review if necessary**
   If adverse decision:
   i. request rationale
   ii. consider MD to MD review
   iii. appeal
Topics to be Covered During the In-Person UM Sessions

• What “Day One” of managed care will look like
• Continuity of Care Requirements
• OMH UM Requirements (OMH Session):
  • PROS Requirements
  • ACT Requirements
  • CDT, IPRT & Partial Hospitalization Requirements
  • Outpatient Clinic Requirements
• OASAS UM Requirements (OASAS Session):
  • Clinic Requirements
  • Opioid Treatment Programs (OTP)
  • Outpatient Rehab Requirements
• State Regulations and How they Drive UM Requirements
• Outlier Management
• Plan Contact Information
Introduction

Overall BH Medicaid managed care implementation incorporates multiple administrative, fiscal and clinical policies to promote a smooth transition to managed behavioral health.

Programs are encouraged to review:

- NYS MRT Behavioral Health webpage: For the foundational vision of integrating BH services into the managed care benefit package.
- The recorded kick off presentation for a full overview of the protective features specific to the integrated of BH services into the Medicaid managed care programs.
From a fiscal and administrative perspective these policies include but are not limited to:

1. Contracting requirements: (e.g. must contract where there are 5 or more enrollees; and, OTP are essential community BH providers so plans must offer all contracts)

2. Payment requirements: Plan must pay at the government rate for first 24 months (including APG rates)

3. Payment mechanism: Plans must utilize the 3M grouper or an exact replica to ensure proper payment

4. Claims submission for APG services: Generally follows the same claim construction as in FFS (e.g. rate codes / HCPCS / CPT and modifiers)

5. Plan Readiness: As part of an overall rigorous review process the plans must test and demonstrate readiness to process claims.
Plans will accept the current modifiers utilized in the APG FFS claiming structure.

OASAS:
All OASAS outpatient programs will be asked to include the HF modifier for tracking purposes, but plans may not deny for failure to include the HF modifier.
OTP programs will continue to utilize the KP modifier for the first medication administration visit of the service week.

OMH:
OMH Providers Should Utilize the Modifiers as specified in the billing manual
Overview

• All Electronic claims will be submitted using the 837i (institutional) claim form

• UB-04 should be utilized when submitting paper claims

• Plans will be required to pay 100% of the Medicaid fee-for-service (FFS) rate (aka, “government rates”) for all authorized behavioral health procedures delivered to individuals enrolled in mainstream Medicaid managed care plans, HARPs, and HIV SNPs when the service is provided by an OASAS and OMH licensed, certified, or designated program.
• When credentialing with OMH-licensed, OMH-operated and OASAS-certified providers, the Contractor (MCO) shall accept OMH and OASAS licenses, operation and certifications in place of, and not in addition to, any Contractor credentialing process for individual employees, subcontractors or agents of such providers. The Contractor shall still collect and accept program integrity related information from these providers, as required in Sections 18 of this Agreement, 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.

• Insurance Law § 3224-a requires insurers and health maintenance organizations to pay undisputed claims within 45 days after the insurer receives the claim, or within 30 days if the claim is transmitted electronically.
Topics to be Covered During the In-Person Sessions

• Overview of Managed Care Claiming and Reimbursement Policy Changes

• Deeper Dive into Billing Guidance

• Detailed review of Field Requirements by Managed Care Organizations for 837i billing form

• Billing Pitfalls and How to Address Billing issues
Topics to be Covered During the In-Person Sessions, cont.

- Common Errors / Mistakes
  Coding/Authorization/Eligibility/etc.

- What to do when things go wrong
  Internal Process Review
  Data Gathering
  Review of Billing Guidelines
  External Communication

- Action items Providers should be taking to ensure readiness for transition to Managed Care

HCBS Manual:

HARP and Mainstream Billing Manual:

Billing Behavioral Health Services Under Managed Care (OMH webpage) :
https://www.omh.ny.gov/omhweb/bho/billing-services.html
  • Behavioral Health Billing Guidance
  • BH HCBS Fee Schedule
  • HARP BH HCBS Rate Codes
Other Resources

• Providers are encouraged to work with plans directly on specific provider/claims issues.

• Providers can submit questions related to delivery of services through Medicaid Managed Care to:

- OMH: OMH-Managed-Care@omh.ny.gov
- OASAS: PICM@oasas.ny.gov
What are the dates for the upcoming In-Person Utilization Management and Billing Sessions?
# In-Person UM & Billing Training Schedule

<table>
<thead>
<tr>
<th>Date</th>
<th>Location</th>
<th>Time</th>
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<tbody>
<tr>
<td>March 31</td>
<td>Albany @ Radisson Hotel Albany</td>
<td>9am-1pm</td>
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<tr>
<td>April 5</td>
<td>Long Island @ Plainview Marriott</td>
<td>9am-1pm</td>
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<tr>
<td>April 7</td>
<td>Hudson Valley @ Poughkeepsie Grand Hotel</td>
<td>9am-1pm</td>
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<tr>
<td>April 11</td>
<td>Buffalo @ Adam's Mark Hotel</td>
<td>9am-1pm</td>
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<tr>
<td>April 12</td>
<td>Syracuse @ SKY Armory</td>
<td>9am-1pm</td>
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<tr>
<td>April 14</td>
<td>Elmira @ the National Soaring Museum</td>
<td>9am-1pm</td>
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<tr>
<td>April 19</td>
<td>North Country</td>
<td>TBD</td>
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Questions?

Upcoming Events

Tuesday, February 10, 2015
Contracting for Managed Care Webinar Overview and Office Hours, 10 am - 12 pm

Thursday, February 26, 2015
Readiness Assessment Follow-up Webinar

view more >

Missed the Kick-off Series?
View a video recording from the Albany presentation.

View Now >

Visit www.mctac.org to view past trainings, sign-up for updates and event announcements, and access resources.

@CTACNY  mctac.info@nyu.edu