Medicaid Managed Care and Family Health Plus

Transition to Mental Health Clinic "Government Rates"

Implementation Date: September 1, 2012

NYS statute mandates that Medicaid Managed Care (MMC) and Family Health Plus (FHP) plans' mental health clinic reimbursement "shall be in the form of fees…which are equivalent to the payments established for such services under the ambulatory patient group (APG) rate-setting methodology". The fees are referred to as "government rates." Plans must have completed their transition to the payment of "government rates" by September 1, 2012.

OMH and DOH recognize that for many plans and clinics movement to "government rates" requires a change in the way they do business. To assist in this change, guidance and information on payment rules and requirements is available on the OMH website at http://www.omh.ny.gov/omhweb/clinic_restructuring/medicaid_managed_care/

To further assist in this transition, we are providing the following additional guidance.

1. **Provider invoicing readiness**. Plans must provide network providers with all the information they need to submit APG or APG equivalent claims to Plans for dates of service starting September 1, 2012. In advance of September 1, Plans must notify all clinics under contract of changes to billing rules including formats for submitting claims, data submission requirements, and required data elements.

2. **Plan payment readiness.** Starting September 1, 2012, Plans must have a functional system in place to pay APG claims or an alternative system that pays the same amount. "Government rates" must be paid for dates of service starting September 1, 2012 and processed within the same timeframes required currently.

   Although the 3M APG software is NOT required to make "government rate" payments, APG software loaded with "government rates" will be available for download from 3M for subscribers by the end of August. A correctly completed "UB04" form submitted by providers and input into the 3M software will generate the calculation of the correct payment.

3. **Compliance with OMH staffing reimbursement requirements**. OMH MMC and FHP clinic staffing reimbursement requirements for licensed and non-licensed staff can be found at

http://www.omh.ny.gov/omhweb/clinic_restructuring/medicaid_managed_care/medicaid_managed_care_staff_reimbursement.pdf.

Effective September 1 Plans CANNOT individually empanel practitioners in OMH licensed clinics. As described in the guidance *Medicaid Managed Care Article 31 Clinic Staffing Reimbursement Standards,* Plans have some options regarding reimbursement for procedures delivered by unlicensed clinic staff in OMH licensed mental health clinics. Plans must advise clinics in writing if they plan to limit reimbursement to only procedures provided by staff in categories # 1 to #3 of this document. All such limitations are PROSPECTIVE from the date the clinic receives such notice. In the absence of notice to the contrary, ALL medically necessary procedures delivered by staff authorized in OMH Part 599 regulations and/or guidelines SHALL be reimbursable by the plan, provided they are a covered benefit. Plans must inform clinics of any documentation requirements necessary for payment for procedures delivered by either licensed or non-licensed staff.

While Plans are not required to follow Medicaid FFS in their approach to payment for services provided by non-licensed staff, information on how non-licensed staff are claimed to Medicaid fee-for-service can be found on page 29 of the Part 599 guidance at http://www.omh.ny.gov/omhweb/clinic_restructuring/part599/guidance.pdf. Currently clinics billing Medicaid fee-for-service for procedures delivered by non-licensed practitioners submit the OMH unlicensed practitioner ID (02249154). This is the ONLY practitioner information they put on the claim. It is used in place of the NPI and ALL other information - name, license etc. - is blank.

4. **Reimbursement for Part 599 services**. Plans must provide the entire range of Part 599 clinic services in a manner accessible to members providing it is a covered benefit. Subject to Plan "Medical Necessity" determinations/service authorizations, in the absence of contractual changes between the Plan and clinic regarding the scope of benefits or Plan written notification to the clinic that specific Part 599 procedures are not covered by existing contracts or forthcoming contracts, clinics performing any of the Part 599 services listed in the "government rate" required services chart (http://www.omh.ny.gov/omhweb/clinic_restructuring/medicaid_managed_care/OMH_required_services.pdf) will be reimbursed at the government rate. Thank you all for your efforts in making this transition as smooth as possible.

Vallencia Lloyd

Director of Division of Managed Care

New York State Department of Health

Norman Brier

Director of Financial Planning

New York State Office of Mental Health