NEW YORK STATE | Department of Health | Office of Mental Health | Office of Alcoholism and Substance Abuse Services

Behavioral Health Provider and Enrollee Contract Protections Refresher

February 14, 2018

Medicaid Managed Care Model Contract

This presentation outlines contractual requirements (Medicaid Managed Care Model Contract) that are relevant to providers who serve individuals in the behavioral health system.

New York State (NYS) has provided Medicaid Managed Care Organizations (MMCO aka MCO aka Health Plans aka Insurance Company) with specific legal requirements and accompanying guidance regarding the process of entering into agreements with providers of these services that address the following:

1. Promoting financial stability through payment and claiming requirements;
2. Ensuring Medicaid Managed Care plans establish adequate behavioral health provider networks; and
3. Supporting access to and removing barriers to behavioral health treatment and recovery services.

Medicaid Managed Care Model Contract

Providers can access the approved Medicaid Managed Care Model Contract (including behavioral health provisions as amended October 1, 2015) on the NYS Department of Health website:

- https://www.health.ny.gov/health_care/managed_care/docs/medicaid_managed_care_fhp_hiv-snp_model_contract.pdf

Behavioral Health Contract Protections

Payment Protections

Government Rate Mandate- Government rate is the minimum reimbursement rate a provider can be paid

- Requires MMCOs to pay the APG (Ambulatory Patient Group) or Medicaid government rate for all OMH licensed or OASAS certified ambulatory behavioral health services, including behavioral health home and community based services (HCBS), to Medicaid eligible enrollees unless an alternative payment arrangement is approved by NYS.
- This mandate extends beyond clinic services paid at APGs, to include all other ambulatory behavioral health services paid at government rates.
- If a behavioral health provider bills MMCO less than APG/Medicaid government rate, MMCO must pay provider APG/Medicaid government rate.
- If a provider submits a claims with an APG/Medicaid government rate, the MMCO cannot reimburse or pay less than the APG/Medicaid government rate.

Payment Protections

- **Time to File Claims-** Providers are required to submit health care claims within 90 days after the date of service for Medicaid Managed Care Plans. MMCOs shall not require providers to submit claims less than 90 days after the date of service. However, some MMCOs may allow providers to submit claims up to 180 days. Please review your contract for information.

- **Promptly Pay Claims**- Insurers are required to pay claims for health care services within 30 days of receipt of a clean claim if the claims are submitted electronically and within 45 days of receipt if the claims are submitted on paper or by fax. NYS prompt pay statute is described in New York State Insurance Law § 3224-a.

Network Protections

- Contracting/Credentialing Protections-
  - State-designation of providers will suffice for the Plan's credentialing process.
  - MMCOs shall not separately credential individual practitioners of:
    - OMH licensed and OASAS certified program
    - Adult BH HCBS Designated Provider
  - MMCOs may still collect and accept program integrity related information
- For in network integrated outpatient service providers, Plans must contract for the full range of integrated outpatient services provided by such provider.
- Serving 5 or more for members (transitional requirement)- MMCOs must offer contracts to any OMH or OASAS provider with five or more active plan members (active in Rest of State until 7/1/18)
- Plans must meet minimum network standards as outlined in the Model Contract

Network Protections

All Products Clause-

- Under no circumstances is the plan allowed to require that the provider participate in plan's non-Medicaid lines of business

Service Access Protections

No Prior Authorization- The Plan shall not require prior authorization for either urgent or non-urgent ambulatory services delivered by:

1. OASAS certified Part 822 outpatient clinics (including intensive outpatient services),
2. Outpatient rehabilitation and opioid treatment programs,
3. OASAS certified Part 816 medically supervised outpatient withdrawal and stabilization programs,
4. OMH Part 599 licensed outpatient clinics (including community mental health services),
5. Integrated clinics

BH Pharmacy Access - Immediate access / no prior authorization for BH prescribed drugs for 72 hour supply; and 7 day supply for prescribed drug or medication associated with the management of opioid withdrawal and / or stabilization.

Link to prior authorization guidance: https://www.omh.ny.gov/omhweb/bho/docs/prior-concurrent-auth-ambulatory-bh.pdf

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Service Access Protections

- **BH Self-referrals**-Enrollees may obtain unlimited self-referrals for Mental Health and Substance Use Disorder assessments from participating providers without requiring preauthorization or referral from the enrollee's Primary Care Provider.
- **Level of Care for Alcohol and Drug Treatment Referral (LOCADTR)-** Use of the OASAS LOCATDR 3.0 for SUD is mandated for level of care determination.
  - https://www.oasas.ny.gov/treatment/health/locadtr/index.cfm
- **New law effective January 1, 2017** No prior authorization or concurrent review for 14 days.
  - **Must be medically necessary – determined by designated tool**
  - Inpatient includes – detox, IPR and Residential (Part 820).
  - In State and In-Network
  - Provider notification within 48 hours of admission and initial treatment plan
  - Provider must regularly assess the need for continued stay and move if clinically appropriate.
  - Periodic Consultation is required - Provider and Plan should communicate!
  - Retrospective Review Permitted
  - No yet in contract, but will be included in next cycle.

Best Practices- Provider Agreements

Review contracts and strike and/or amend conflicting contractual language where possible.

- Add language consistent with the following:
  - "For purposes of the Behavioral Health transition, where any terms of this Agreement contradict or conflict with terms in the State Managed Care Model Contract and corresponding guidelines, the Managed Care Model Contract and guidelines shall prevail."
- Ensure DOH Standard Clauses are included in or attached to the provider agreement. These clauses are designed to ensure adherence to State Medicaid Managed Care Model Contract
  - https://www.health.ny.gov/health_care/managed_care/hmoipa/docs/standard_clauses_revisions.pdf
- Be aware of "Lesser of" language which should not exist
- Ensure the services you are contracted to provide are accurately listed in the MMCO contract
- Review contract to make sure that:
  - All locations/services/programs are reflected in your contract.
  - You are contracted with the MCO's Medicaid line of business.
    - There has been confusion where providers are contracted with multiple lines of business (Medicaid/ Medicare/ Commercial/ MLTC)

Best Practices- Provider Agreements

- If you are already contracted with a Plan, review claims activity to ensure Plans are paying at the appropriate rates.
- Providers are **strongly** encouraged to sign single case agreements in cases of continuity of care to ensure there is no disruption in the delivery of service or payment
  - Single case agreements are also protected under the laws of government rates for ambulatory services
  - Utilization management rules apply under a single case agreement

Best Practices- Payment for Services

- MMCOs must pay based on all OMH/OASAS posted rate and procedures codes

  https://www.omh.ny.gov/omhweb/bho/billing-services.html
- For UM authorizations, Plans and Providers must follow units as outlined by OMH/OASAS Coding Taxonomy. If provider is not doing it correctly, claims will be denied
- Authorization letter is NOT a guarantee of claims payment, ensure you follow listed coding guidelines

Managed Care Contracting Resources for Providers

- **DO NOT WAIT TO CONTACT THE STATE REGARDING ANY CONTRACTING and CREDENTIALING ISSUES!!!!!!!!**
- Submit questions, comments and specific issues regarding the Behavioral Health Transition to the following mailboxes:
  - OMH: OMH-Managed-Care@omh.ny.gov.
  - OASAS: Practice Innovation and Care Management (PICM) Mailbox.
  - DOH: Behavioral Health Transition to Managed Care

More technical assistance will be available on the MCTAC website:

- http://www.ctacny.org/

Additional Resources for Providers

Medicaid Managed Care Model Contract (including behavioral health provisions as amended October 1, 2015)

- https://www.health.ny.gov/health_care/managed_care/docs/medicaid_managed_care_fhp_hiv-snp_model_contract.pdf

Policy and Guidance for Plans and Providers:

- https://www.omh.ny.gov/omhweb/bho/policy-guidance.html

NYS Department of Health Provider Contract Guidelines for Article 44 MCOs, IPAs, and ACOs

- **https**://www.health.ny.gov/health_care/managed_care/hmoipa/docs/guidelines.pdf

NYS Department of Health Standard Clauses for Managed Care Provider/IPA/ACO Contracts

- https://www.health.ny.gov/health_care/managed_care/hmoipa/docs/standard_clauses_revisions.pdf

OASAS Residential Redesign

- https://www.oasas.ny.gov/ManCare/BHO/ResidentialRedesign.cfm