



Managed Care Tool Kit for Association for Community Living

Updated May 1, 2015



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Introduction

The Association for Community Living, in collaboration with O'Connell & Aronowitz Attorneys at Law and its Healthcare Consulting Group, is pleased to provide to its members this Managed Care Tool Kit as a resource for your use during this time of transition. The Medicaid Redesign Team has launched our communities into the world of managed care which has significant strategic, financial, and operational impacts. This transition will also impact our relationships with our residents, families, and community partners.

The theme of "Building a New Infrastructure – Operating inside Managed Care" indicates the significance of the changes facing Community Residences. New relationships, new jargon, new payment structures, and new processes will require the rethinking and building of operational infrastructure to meet the challenge of shifting from a fee for service model of care to one coordinated and directed by a managed care plan. The following is designed to provide you with information, recommendations and action items to assist in your preparation and planning for this transition.

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Note: This document does not replace, in any manner, the responsibility of the board, director, and staff, of the Community Residence to have full knowledge of the regulations regarding the operations and provision of care in Community Residences. The following material is meant to complement the knowledge of the user and act as a resource.

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Section One: Building a New Infrastructure – Operating Inside Managed Care

Chapter 1: Background

What Is the Blueprint?

Managed Care for Medicaid Behavioral Health Services?

The Medicaid program is the State's largest payor for mental health services, and accounts for 48% of the public mental health system. Inpatient psychiatric services in discrete psychiatric units of general hospitals, private psychiatric hospitals and OMH-operated psychiatric centers represent \$3.67 billion of the approximately \$8 billion total mental health spending.

Under the directive of Medicaid Redesign, the behavioral health system within the Offices of Mental Health (OMH) and Alcoholism and Substance Abuse Services (OASAS) has been targeted for reform. A Medicaid Redesign Behavioral Health Reform Work Group was established and identified two Phases to transition behavioral health (BH) services (mental health and substance use disorders) into a managed care model. The Work Group adopted the following principals to guide the redesign effort:

- Person-centered care management*
- Integration of physical and behavioral health services*
- Recovery oriented services*
- Patient/consumer choice*
- Ensure adequate and comprehensive networks*
- Tie payment to outcomes*
- Track physical and behavioral health spending separately*
- Reinvest savings to improve services for BH populations*
- Address the unique needs of children, families & older adults*

Phase I of the reform included the contracting of Behavioral Health Organizations (BHOs) to work with OMH and OASAS. BHOs performed targeted reviews of inpatient admissions with the purpose of gathering data to identify systemic trends. The information is to be used to support new approaches and evidence-based practices that:

- facilitate transitions from inpatient to the community;*
- sustain engagement in community-based care; and*
- address co-morbid medical problems and co-occurring mental health/substance use disorders.*

The following is a summary of issues found from the review of over 67,000 admissions:

- The FFS population includes many individuals with multiple treatment and care coordination needs.*
- Rates of hospital providers communicating with outpatient providers, scheduling aftercare appointments, and sending discharge summaries to aftercare providers are highly variable.*

Section One: Building a New Infrastructure – Operating Inside Managed Care

Chapter 1: Background

- *Many admitted individuals have physical health conditions requiring follow-up, but rates of scheduled aftercare appointments with a physical health provider for these individuals are low.*
- *This population has high rates of inpatient readmission and low rates of continuity and engagement in post-discharge outpatient services.*
- *Some of the highest volume providers have low rates of individuals successfully transitioning to outpatient services.*

Phase II of the reform is aimed at providing for more effective care coordination. The objective is to transition the BH population, currently receiving BH services in a largely unmanaged fee-for-service (FFS) system, into the managed care program. It is anticipated that this effort will result in more coordinated BH and PH services, reduce inpatient use - especially readmissions, and improve quality by adding additional community based services.

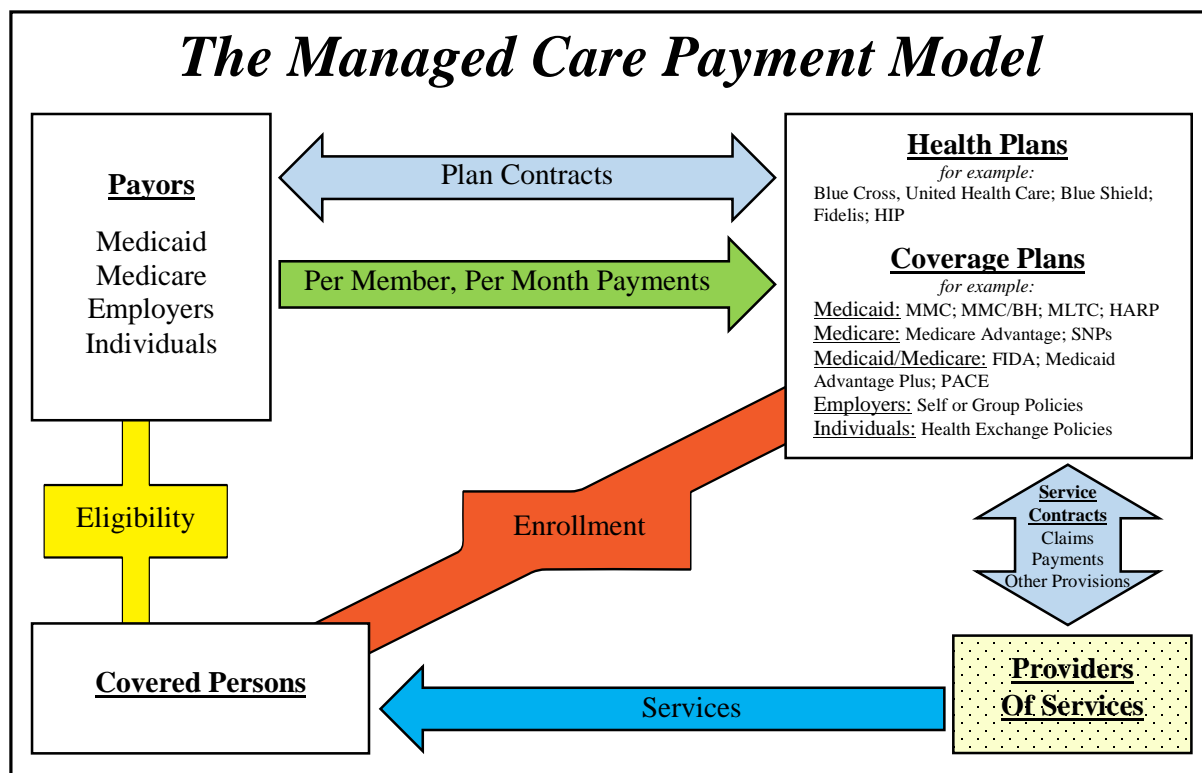
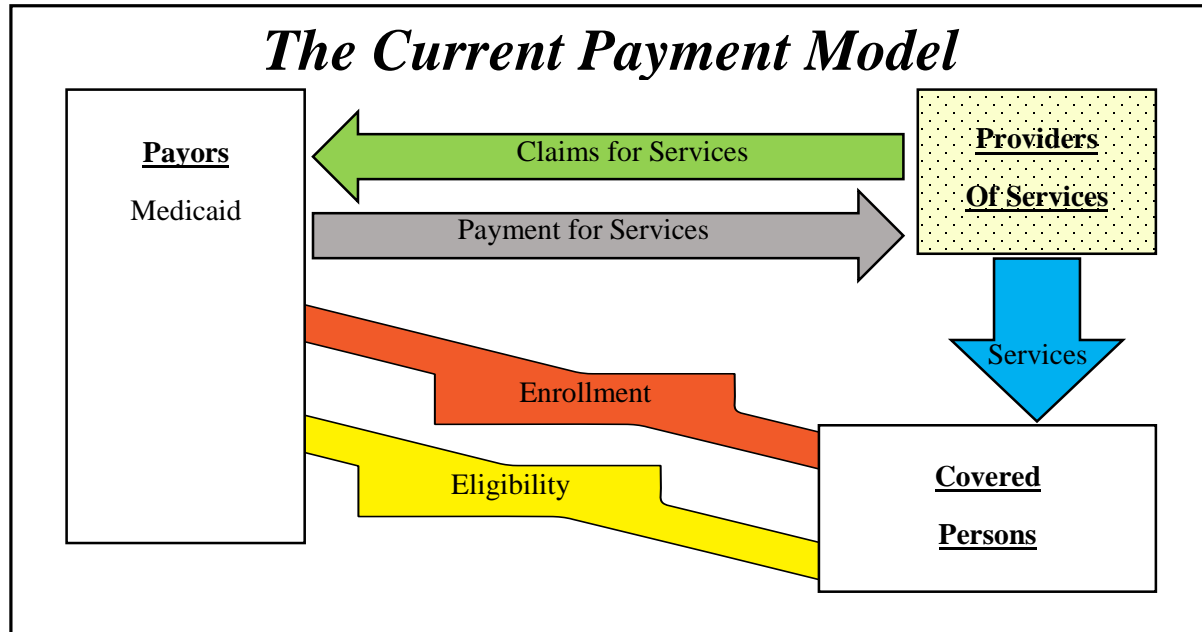
In addition, there are also changes for the “dual eligible population” (Medicaid recipients also eligible for Medicare services). Medicare covers aged and disabled individuals for physical health and some limited behavioral and long term care services (most often associated with rehabilitation). When an individual becomes eligible for Medicare, Medicaid then stops covering these services, but continues to cover services such as long term care, behavioral health and DD services. The dual population is the most costly for both Medicare and Medicaid, therefore several efforts are being made to better integrate Medicare and Medicaid to reduce fragmentation, improve care management and reduce costs.

Under a Medicaid managed care program, the NYS Department of Health contracts with managed care plans that agree to provide or arrange for the provision of an agreed upon set of services (covered benefits) in exchange for a predetermined, pre-paid per member per month(PMPM) or capitation payment. The capitation payment does not vary based on the number of services the managed care plans provide, the managed care plans assume financial risk for providing all covered benefits.

There are “Health Plans”, “Product Lines” within each Plan, and “Coverage Plans” within the “Product Lines”. To use an example – Blue Cross/Blue Shield is an insurance company and “Health Plan” that might have three “Product Lines”, Commercial, Medicaid and Medicare as a result of contracts with employers, individuals or the government. There might be four Coverage Plans within the Medicaid Product Line, i.e., Mainstream Managed Care (including Family Health Plus and Child Health Plus), HARP, MLTC and FIDA (explained below). Each Health Plan will have its own distinct structure and may not provide all product lines or Coverage Plans. The following diagram demonstrates the change for Community Residences and their agencies from the current fee for service Medicaid system to the managed care environment that is evolving.

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Chapter 1: Background

Payment Models



Section One: Building a New Infrastructure – Operating Inside Managed Care

Chapter 1: Background

There will be several ways that either existing or future clients of Community Residences may be enrolled in one of four different Coverage Plans. In order to support clean claims submission, engage in appropriate communication on behalf of clients and manage billing under managed care, it will be critical for Community Residences to understand which Coverage Plan (i.e. Mainstream, HARP) inside the Health Plan (Fidelis, CDPHP) their clients are enrolled in for purposes of physical health, long term care, and behavioral health services. Community Residences must understand when critical eligibility events occur for their clients, such as: attaining Medicare eligibility at 65; if they are in need of and/or receiving long term care services through their Health Plan (home health services for insulin injections); and the client's Medicaid recertification date are all events that can impact on the eligibility for a particular Coverage Plan.

The State's approach to the shift of BH services for the Medicaid population and long term care services for those dually eligible for Medicaid and Medicare into managed care programs is as follows:

Medicaid Managed Care (MMC) Health Plans

For all adults served in MMC health plans throughout the State, the qualified plan will integrate and provide all Medicaid State Plan covered services for Mental Illness, Substance Use Disorders (SUDs) and Physical Health (PH) conditions. However, plans must meet the criteria contained in the request for qualification (RFQ) and be approved by the State to qualify to administer the BH benefit. If plans do not qualify, their existing clients that want the full BH benefit will have to change plans.

Health and Recovery Plans (HARPs)

*For adult populations meeting the serious mental illness (SMI) and SUD targeting criteria and risk factors, the State will enroll individuals in specialty coverage plans within the qualified MMC health plans statewide, called HARPS. Within the HARPs, an enhanced benefit package (referred to as "HCBS or Home and Community Based Services") in addition to the State Plan services will be offered for enrolled individuals who meet both targeting and needs-based criteria for functional limitations. The needs-based criteria are in addition to any targeting and risk factors required for HARP eligibility. The enhanced benefit package will help maintain participants in home- and community-based settings. These enhanced benefit packages will be provided by the qualified full-benefit HARPs. In addition, individuals eligible for enrollment in a Medicaid Managed Care Plan who are 21 and over **not** residing in a nursing home, dually eligible for Medicare or in an OPWDD program, and who have a serious mental illness and/or substance use disorder (SMI/SUD) will be eligible for HARP enrollment. Individuals presenting with serious functional deficits through case reviews or a separate screening may also be enrolled.*

Plans must meet the criteria contained in the request for qualification (RFQ) and be approved by the State to qualify to administer the HARP benefit. If plans do not qualify, their existing clients that want the full HARP benefit will have to change plans.

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Chapter 1: Background

Managed Long Term Care (MLTC) Plans

For adults over 18 years of age and eligible for Medicaid and Medicare (duals) who require more than 120 days of community based long term care services and those who meet the nursing home level of care (for Programs of All-Inclusive Care for the Elderly and Medicaid Advantage Plus). The benefit consists of the State Plan long term care services, including the Long Term Home Health Program and nursing home stays, but not any of the physical health services, which are covered by Medicare. The transition of this population began in New York City in 2012 and has continued into Long Island, Westchester and upstate counties; now over 135,000 people are enrolled. In addition individuals between the ages of 18 and 20 may voluntarily enroll in a MLTC Plan. The conditions of eligibility are:

- require more than 120 days of community based long term care services; and*
- meet Nursing Home Level of Care criteria.*

Non-dually eligible individuals, who are not otherwise considered mandatory for Mainstream Managed Care, may voluntarily enroll in a MLTC plan with the same eligibility conditions. The state has undertaken a process to create a Conflict Free – Evaluation and Enrollment Center (CFEEC) administered by the Medicaid Enrollment Broker to determine eligibility for services using a standardized assessment tool. This feature was implemented in October of 2014 starting in Bronx and New York Counties and aimed at addressing the potential conflict of MLTC Plans assessing the need for service eligibility. It is anticipated that this process will be applied to the HARP –eligible population as well. As of April 2015 this process has been implemented in all downstate counties and upstate counties except for certain counties that are more rural.

Fully Integrated Duals Advantage (FIDA)

The State is also participating in the Federal Medicare/Medicaid Demonstration Program that allows for the alignment of Medicare and Medicaid payments under a capitated model. New York's program is called Fully Integrated Duals Advantage (FIDA). This program is intended to cover all needed services – both physical health and behavioral health for the dual population that is either in need of more than 120 days of community based services or residing in nursing homes. The full range of BH services are included in FIDAs, including Community Residences.

Homework:

- ☐ *Create a tracking system for all current clients by Health Plan and Coverage Plan.*
- ☐ *Check which Health Plans are approved for your service area (see list by County in Appendix).*

Section One: Building a New Infrastructure – Operating Inside Managed Care

Chapter 2: Eligibility

Who Is Eligible?

Important Note: Eligibility can vary depending on type of Coverage Plan. As mentioned above, insurance companies can have several “product lines” such as Medicaid, Medicare or Commercial. Each product line may also have different Coverage Plans. For example Fidelis is approved to enroll Medicaid Mainstream eligible, Medicaid Managed Long Term Care eligible as well as Medicare Advantage eligible in certain counties of the state. The Fully Integrated Duals Advantage (FIDA) is being developed for New York City, Nassau, Suffolk and Westchester and began to enroll Medicaid and Medicare eligible in 2015; however the enrollment has been limited thus far to New York City and Nassau County. You should have a basic understanding of what types of individuals are eligible for which programs prior to entering into a contract. Also, you should understand for which Coverage Plans your current clients are, and future clients might be, eligible.

For the Medicaid transition of BH, eligibility is dependent on the Medicaid beneficiaries’ status related to BH needs:

- Individuals who are Medicaid eligible under Temporary Assistance to Needy, Safety Net Adults, Supplemental Security Income (SSI) and Family Health Plus (FHP) who have previously received BH services under FFS will be required to select a qualified PH/BH Health Plan.

This means that all Medicaid-only individuals with BH needs living in the community will enroll in Medicaid Managed Care Plans; they will then be directed based on the significance of their BH needs. A single Health Plan could be both a BH qualified plan and a HARP qualified plan – serving both BH populations.

New York estimates that there are over 140,000 Medicaid Managed Care enrollees meeting targeting criteria and risk factors that will be enrolled in the HARPs – 85,000+ in New York City and 60,000+ in the rest of the state. The vast majority of clients being served in Community Residences are HARP eligible. The last time the state analyzed this, it was estimated that more than 98% of CR residents were HARP eligible

Since nearly all HARP eligible individuals are already enrolled in MMC Plans for their healthcare it is important for Community Residences to understand which Plans are likely to become HARP approved Plans. The following provides relevant data:

Number of Projected HARP Eligible by Plan and Location

Health Plan Name	New York City	Rest of State	Total
No Plan	12,577	11,538	24,115
NYS Catholic Health Plan	9,457	16,856	26,313
Health First	19,759	1,609	21,368
Metroplus Health Plan	13,224		13,224

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Chapter 2: Eligibility

HIP (Emblem)	5,771	2,118	7,889
Excellus		7,801	7,801
United Healthcare of NY	4,213	3,514	7,727
Amerigroup New York	7,246	317	7,563
Affinity Health Plan	4,952	2,053	7,005
Hudson Health Plan		4,091	4,091
MLTC Plans (all combined)	3,000	389	3,389
Capital District PHYS Health Plan		3,321	3,321
Independent Health Association		2,407	2,407
Health Now NY		2,035	2,035
Today's Options		1,733	1,733
Univera		1,678	1,678
VNS Choice SNP	1,362	10	1,372
Amida Care SNP	1,303		1,303
Wellcare of New York	737	390	1,127
MVP Health Plan		1,108	1,108
MetroPlus Partnership Care SNP	925		925
Neighborhood Health Provider	512	128	640
TOTAL	85,038	63,096	148,134

While 16% (24,115) of these individuals are not in Plans; the remaining 84% are already enrolled. Those individuals not enrolled are likely to be eligible for both Medicaid and Medicare or in some care setting that is currently excluded from Mainstream Managed Care, such as inpatient psychiatric settings.

Homework:

- ☐ *Identify if current clients are in any of the Health Plans in the Projected HARP Eligible Chart.*
- ☐ *If not, verify which Health Plans are approved for your service area so that you can reach out to start a dialogue.*

Section One: Building a New Infrastructure – Operating Inside Managed Care

Chapter 3: Covered Benefits

What Services Are Covered?

All physical health services currently part of the Managed Care benefit and the following BH Services:

- *Medically supervised outpatient withdrawal (OASAS services)*
- *Outpatient clinic and opioid treatment program (OTP) services (OASAS services)*
- *Outpatient clinic services (OMH services)*
- *Comprehensive psychiatric emergency program*
- *Continuing day treatment*
- *Partial hospitalization*
- *PROS: Personalized Recovery Oriented Services*
- *ACT: Assertive Community Treatment*
- *Intensive case management/ supportive case management (transitioning to Health Home)*
- *Health Home Care Coordination and Management*
- *Inpatient hospital detoxification (OASAS service)*
- *Inpatient medically supervised inpatient detoxification (OASAS Service)*
- *Inpatient treatment (OASAS service)*
- *Rehabilitation services for residential SUD treatment support (OASAS service)*
- *Inpatient psychiatric services (OMH service)*
- *Rehabilitation services for clients of community residences**

**NOTE: In Year Two of Transition*

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Chapter 3: Covered Benefits

Additional Services for HARP (referred to as HCBS):

Rehabilitation:

- *Psychosocial Rehabilitation*
- *Community Psychiatric Support and Treatment (CPST)*
- *Mobile Crisis Intervention*
- *Empowerment Supports - Peer Supports*

Habilitation:

- *Habilitation / Residential Supports in Community Settings*

Respite:

- *Short-term Crisis Respite*
- *Intensive Crisis Respite*
- *Non-medical transportation*
- *Family Support and Training*
- *Employment Supports:*
- *Pre-vocational Services*
- *Transitional Employment*
- *Intensive Supported Employment*
- *On-going Supported Employment*
- *Education Support Services*

The State has released a manual for providers regarding HCBS. For manual, visit:

<http://omh.ny.gov/omhweb/guidance/hcbs/html/services-application/index.htm>.

Any questions can be directed to BHO@omh.ny.gov. This also includes information on approved providers.

Homework:

- ☐ *Review any contract for definition of services and if such definition aligns with regulatory standards.*
- ☐ *Familiarize yourself with designated providers to determine alignment with agency capacity and capability..*

Section One: Building a New Infrastructure – Operating Inside Managed Care

Chapter 4: Enrollment

How Are Current Medicaid Recipients Transitioned?

Individuals who are already enrolled in MMC Plans will be notified that their BH/SUD services are being added as covered benefits under their current Plan, as long as their Plan has become qualified. It is expected that all Plans will become qualified because if they do not, they will no longer be able to be a Medicaid Managed Care Plan in NY. Becoming a HARP, on the other hand, is voluntary.

Individuals will be identified as potentially needing HARP services on the basis of historical service use or completion of a HARP eligibility screen. From this data the State will provide rosters to MMC Plans of their members whose service use histories indicate a need for HARP. Individuals initially identified as HARP eligible who are already enrolled in an MMC Plan with a HARP will be passively enrolled in that HARP. This is intended to maintain access to current physical health service providers as the new BH benefits are added. Those individuals will also be contacted by the Medicaid enrollment broker (New York Medicaid Choice)

The passive enrollment process will include notification to the MMC Plan member to describe the HARP and the covered services. They will have the ability to stay in their existing MMC Plan or choose another HARP – in doing so they may lose the connection to their physical health providers. They will have thirty days after passive enrollment to opt out of HARP or enroll in a different HARP.

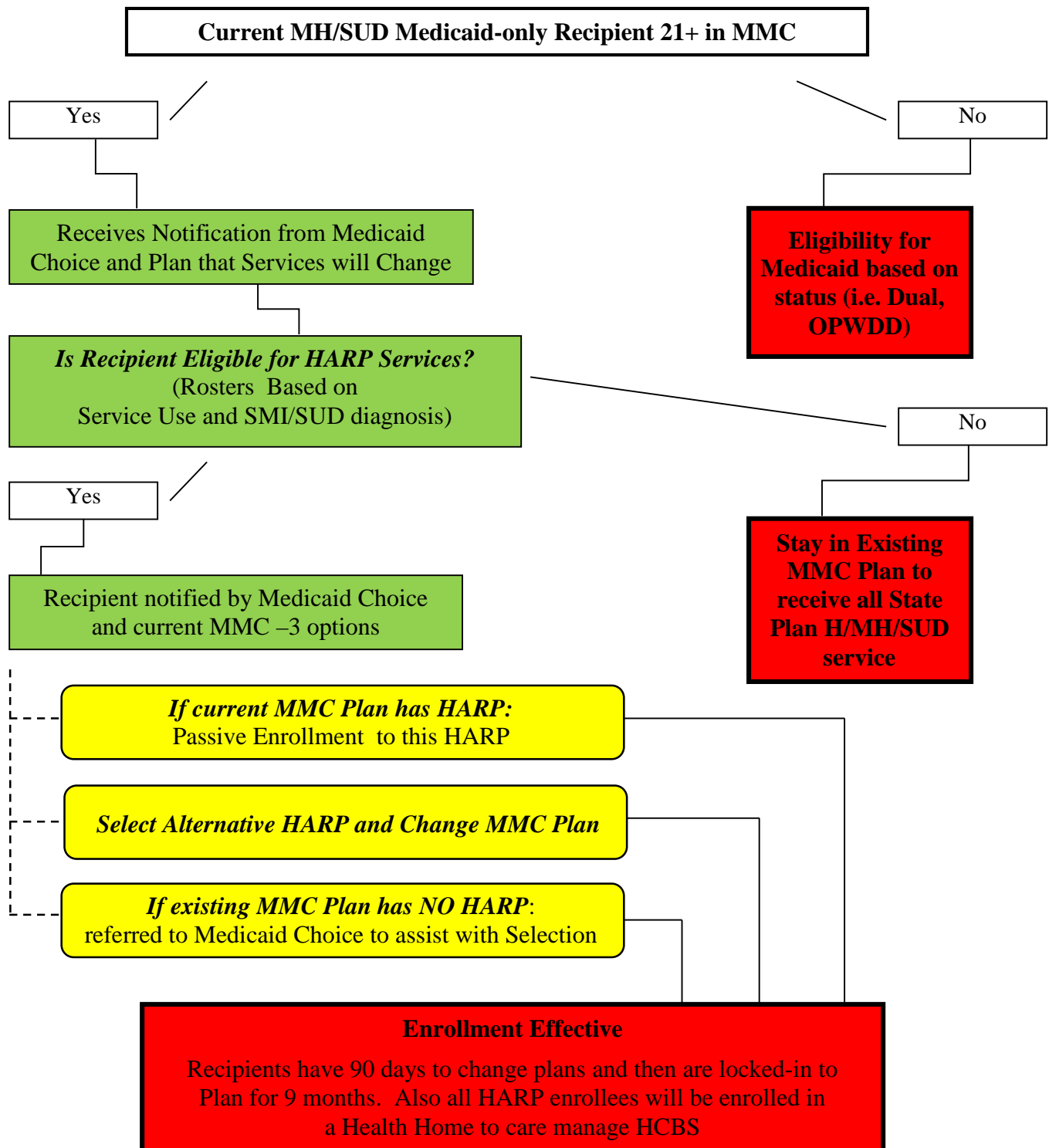
*Individuals initially identified as HARP eligible who are already enrolled in an MMC Plan **without** a HARP will **NOT** passively enrolled. They will be notified by their Plan of their HARP eligibility and referred to the Medicaid enrollment broker (New York Medicaid Choice) to help them decide which Plan is right for them. Individuals initially identified as HARP eligible **but not** currently enrolled in a MMC Plan will be referred to Medicaid Choice to help them decide which Plan is right for them. Information will be provided to Medicaid beneficiaries in writing information on how to contact Medicaid Choice. Individuals who are in an HIV SNP will be able to receive HCBS through their HIV SNP. They too will be notified of their HARP eligibility and referred to New York Medicaid Choice to assist in any Plan selection or change.*

The website is: <http://www.nymedicaidchoice.com>

Once enrolled in the HARP, members will have 90 days to choose another HARP or return to a MMC Plan before they are locked into the HARP for 9 months from the date of enrollment.

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Chapter 4: Enrollment

MEDICAID ONLY POPULATION ENROLLMENT PROCESS



Section One: Building a New Infrastructure – Operating Inside Managed Care

Chapter 4: Enrollment

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As of April 2015, the enrollment process will start in July 2015 in New York City. First letters will be sent to approximately 20,000 HARP eligible in July 2015 with anticipated enrollment by October then additional 20,000 letters to be sent in August for November enrollment and another final group is expected in September for December enrollment.

The first implementation of service delivery by Mainstream Plans and HARPs will be October 1, 2015 and for ONLY non-HCBS behavioral health services. Due to HARP enrollment being phased in the new HCBS features will begin for those eligible in January 2016.

Community Residences will need to be prepared to encourage clients to respond to any notices regarding their coverage by Medicaid. The process typically includes a limited number of days to respond before the Medicaid system will take action.

Community Residences are encouraged to provide clients with a list of MMC Plans with which the Community Residence contracts.

Homework:

- ❑ *Go to Medicaid Choice website: www.nymedicaidchoice.com to familiarize yourself with role and function of the enrollment broker.*
- ❑ *Understand your referral patterns – where do your clients come from? Being in the same Plans as existing referral sources will be important during and after the transition.*

Section One: Building a New Infrastructure – Operating Inside Managed Care

Chapter 5: Plan Qualifications

Which Plans Are Qualified?

In order for a Plan to be approved by the State to participate as a Medicaid Managed Care Plan there are several standards that must be met – these were all listed in the RFQ to which all Plans were required to respond in order to become qualified.

The State anticipates that final approval for Plans in the New York City region will be approved by July 2015. For the rest of the State, an RFQ is planned for June 2015 with approval process (desk and readiness reviews) to be completed in time for enrollment processes to begin in April 2016.

Homework:

- ☐ *Stay apprised of final approvals of HARP.*
- ☐ *Participate in ACL related educational opportunities.*
- ☐ *Familiarize yourself with Plans approved for your catchment area.*

Section One: Building a New Infrastructure – Operating Inside Managed Care

Chapter 6: Network Development

What is Network Development?

The development of an adequate network of providers for all covered services is a required standard for approval of a Health Plan by the State and/or Federal Government. In existing MMC Plans the network standards are typically based on geographic distance and waiting times for access. The State has developed a more expansive set of requirements for the BH and HARP plans.

The State requires that MMC Plans assure:

- *Network adequacy;*
- *Appointment access;*
- *Appropriate penetration rates;*
- *Development of network resources in response to unmet needs;*
- *New service development as specified in the benefit package;*
- *Adequacy of the provider network (integrated BH/PH providers) to offer members choice of providers; and;*
- *Contracting with qualified service providers in compliance with federal and State laws.*

The State is specifying the qualifications of the individual(s) providing oversight for network development for BH and HARP Plans. For BH Plans the person(s) should have experience working in a BH managed care setting or BH clinical setting, and demonstrated expertise in network development for MH and SUD services for:

- *Adults;*
- *Transition age youth;*
- *High risk groups such as individuals with SMI, co-occurring major mental disorders and SUDs and those involved in multiple services systems (education, justice, medical, welfare, and child welfare);*
- *Individuals with I/DD in need of BH services;*
- *Individuals with a MH condition or a SUD and co-occurring chronic physical health conditions; and;*
- *Individuals with a SUD in need of medication-assisted treatment, including methadone and buprenorphine for opioid dependence.*

The individual(s) are required to be responsible for network development, contracting, credentialing, and provider communications. This position must work at sites located in NYS. These requirements are intended to assure appropriate oversight of network development and communication with providers.

Section One: Building a New Infrastructure – Operating Inside Managed Care

Chapter 6: Network Development

Plans will be expected to provide details to the State on how their experience qualifies them to manage BH benefits and networks in NYS. The State requires the following for network development activities inside Plans:

- The incorporation of the preferences of members and their families in the design of services and supports (person-centered care planning);*
- The incorporation of a holistic approach in the design and delivery of services and supports, including assisting the member with obtaining and maintaining stable, safe, permanent housing; meaningful employment; social networks; and health and wellness.*
- Collaborating with consumer and/or family-run services, demonstrated by incorporating peer-run services into the provider network.*
- The use of self-management and relapse prevention skills, Wellness Recovery Action Plans (WRAPs), and psychiatric advance directives.*

Plans proposing to manage a HARP product line must meet additional requirements. The Plan or its staff shall have a proven track record in providing services to Medicaid or other government-sponsored Plans for similar members and populations demonstrated by:

- Experience and demonstrated success managing BH care for special populations including, but not limited to adults with SMI, adults with functionally limiting SUD, individuals experiencing a first episode psychosis, individuals with SMI and criminal justice involvement, adults residing in permanent supportive housing (PSH) or other types of community housing and homeless adults.*
- Experience and demonstrated success in operating a comprehensive care management program for HARP-like populations.*
- Sufficient resources with the relevant expertise to customize their technology platform to support compliance with federal HCBS requirements. This includes evaluating the adequacy of plans of care compared to assessed needs and that services are delivered consistent with the plan of care.*
- Sufficient resources for the Plan to review external functional assessments, service eligibility determinations, and plans of care for SMI and/or SUD populations.*
- The Plan must have a BH advisory subcommittee reporting to the MCO's governing board. The subcommittee will include peers, providers, local government and other key stakeholders.*

In addition, the State has included a mechanism in the network standards to assure that there is continuity of services. Plans will be required to contract with:

- BH agencies licensed or certified by OMH or OASAS who currently serve five or more Medicaid managed care enrolled beneficiaries for at least the first 24 months of operation;*

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Chapter 6: Network Development

- *NY State determined essential community BH providers (at this time these include State operated behavioral health programs);*
- *All Opioid Treatment programs in their service area to ensure regional access and patient choice where possible;*
- *OASAS residential programs and pay their allied clinical service providers on a single case or contracted basis for members who are placed in an OASAS certified residential programs to ensure continuity of care for patients placed outside of the MCO/ HARP's service area;*
- *An adequate number of behavioral health clinic providers that offer urgent and non-urgent same day, evening, and weekend services;*
- *Crisis service providers;*
- *Clinics holding a state integrated license shall contract for the full range of services available pursuant to that license (this integrated license is not yet created by the State).*

All such providers must meet and maintain compliance with all Federal and State regulations.

HARP requirements include a standard that all enrollees (with consent) also be enrolled in a Health Home. It is intended that the Health Home will serve as care manager for all services including the Home and Community Based Services provided. Health Homes and Plans are to collaborate around data sharing and management of high need HARP members.

To preserve continuity of care, HARP enrollees will not be required to change Health Homes at the time of the transition to a HARP. HARPs will be required to pay on a single case basis for individuals enrolled in a Health Home when the Health Home is not under contract with the HARP.

Homework:

Community Residences should carefully review any contract and inquire about the status of the Plan's approval as a State Qualified Plan for BH services.

- ☐ *If approached to become a network provider ask for the contact information of the BH liaison for the Plan.*
- ☐ *Understand in which Health Home(s) your current clients are enrolled.*
- ☐ *Understand which Health Homes are approved for your service area.*
- ☐ *Understand which Plans are approved for your service area as they are required to have a contract to have your Community Residence in their network due to the 5 or more Medicaid managed care enrolled beneficiaries standard.*
- ☐ *Ask Plan contacts about participation in their BH Advisory Subcommittee*

Section One: Building a New Infrastructure – Operating Inside Managed Care

Chapter 6: Network Development

How Are Rates and Premiums Developed?

Plans will have an integrated premium (for both BH and PH) established for this specific BH population. The State contracts with Mercer Government Human Services Consulting to provide actuary review and development of accurate premiums. Under Federal law the premiums paid to Medicaid Plans must be “actuarially sound”. The basis for initial premiums are historic costs of the beneficiary groups for the specific covered services, adjusted for any program changes to create a medical services component and then a non-medical component is derived based on historic costs and policy determinations.

An Example of CY 2015 Draft HARP Rate Development looks like this:

Region: New York City

Service Group	Blended Base Data
Inpatient Psych.....	\$307.09
Detox	\$121.60
Inpatient D&A.....	\$20.58
Outpatient Psych.....	\$162.88
Outpatient D&A	\$110.71
Emergency Room – BH	\$10.93
Intensive Psychiatric Rehabilitation Treatment	\$0.47
Personalized Recovery Oriented Services	\$17.17
Assertive Community Treatment	\$23.25
Continuing Day Treatment	\$10.18
Partial Hospitalization	\$1.50
Comprehensive Psychiatric Emergency Program.....	\$3.82
Assessment.....	\$0.10
Nursing Facility	\$56.70
Inpatient Acute	\$458.08
Ambulatory Surgery	\$22.85
Clinic	\$28.10
Emergency Room.....	\$40.50
Other Outpatient.....	\$203.00
Physician Specialist	\$76.95
Primary Care	\$57.94
Tests, Lab and X-rays.....	\$56.64
Dental	\$15.39
Family Planning	\$0.91
Gross Medical Expenses	\$1,807.33

Blended Base Data with Program Changes	\$1,822.81
Final Medical PMPM with Trend	\$2,047.04
Managed Care Savings	(\$130.04)
	-6.4%

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Chapter 6: Network Development

New Benefits Adjustments:

Pharmacy	\$494.53
FHPlus Additional Benefits	\$8.57
SUD SPA Services	\$42.07

Gross Medical Expenses \$2,462.16

Non-Medical Expense Loads:

Administrative Expenses	\$185.37
	6.9%
Underwriting Gain	\$26.74
	1.0%

Rates with Admin / Underwriting Gain \$2,674.27

- NOTES:
1. Data is based on eligibility data for HARP eligible FFS and MC enrollees on a monthly basis.
 2. Data reflects only members age 21 and over.
 3. All maternity services are excluded from this exhibit.
 4. This information is not **FINAL**.

*Premium rates for HARP Plans are significant due to the nature of the historical costs of inpatient (both psychiatric and acute) care, pharmacy, and emergency services. Plans will receive these payments on a monthly basis for all service needs. **For 2016 these rates will need to be revised to include the underlying cost of Community Residences so that the rates reflect all services in the benefit package.** The data used will be the historic cost to Medicaid for the eligible population. The rates are Regional and the Appendix includes the HARP rates for the Rest of the State.*

Section One: Building a New Infrastructure – Operating Inside Managed Care

Chapter 7: Timeline

What is the Timeline for Implementation?

The current implementation dates for the behavioral health transformation to managed care are:

- *July 2015: Adults in NYC (HARP and Qualified Mainstream Managed Care Plans)*
- *April 1, 2016: Adults in Rest of State (HARP and Qualified Mainstream Managed Care Plans)*
- *January 1, 2017: Children in NYC*
- *July 1, 2017: Children in Rest of State*

These dates were delayed twice from an original January 1, 2015 start and then again from an April 1, 2015 start date. The Community Residence service will not be added to the benefit package until 2016, or later if this too is delayed.

Adult implementation in NYC is slated to begin in July 2015 with letters sent to individuals eligible for HARPs. Individuals will be sent letters in three phases, stretching through September and October of 2015. Enrollment of individuals who receive letters is scheduled to begin in October 2015 and close in January 2016, with January 1, 2016 as the start date for HCBS.

In the rest of the state, enrollment letters are scheduled to be sent in April 2016 with enrollment beginning in July 2016.

As of this revision, the State continues to work to receive final Federal approval.

Homework:

- ❑ *Understand where your clients receive outside BH services so that coordination with Plans can occur for 2015.*

Section Two: Agency Preparation

Chapter 1: Site Preparation

Environmental Scan

Organizations must be aware of the managed care plans available in the communities they serve. Tracking clients' Plan enrollment is important as all types of service (primary care, urgent, emergency, behavioral health) will be inside a Plan. In addition, having a sense of the market leaders in your community is important as these are the Plans that will have sufficient enrollment to impact referrals within provider networks. Market leaders are typically defined as having high enrollments, networks that include essential providers, and are financially stable. Understanding your market supports good decision-making related to contract development as well as support for your clients.

If you have become a Designated Provider of HCBS it is important to utilize the manual.

You are encouraged to use the materials attached in the Section 5 to assist in your environmental scan. The materials include a list by Plan name that identifies which counties they operate in and which product lines they support (Medicaid, Medicare, and Commercial). In addition there is data on enrollment by Health Plan and Coverage Plan as of most recent data released by the State. This can be used to identify market leaders as well as new Plans getting started. The approved Medicaid Plans (all types) are the likely candidates to become BH and/or HARP Plans. As an example: Fidelis (NYS Catholic Health Plan) is approved for most counties and therefore is likely to be reaching out to develop network relationships.

Homework:

- ☐ *Review the materials to understand which Plans are in your service area.*
- ☐ *Review the HCBS manual to prepare for delivery of services.*
- ☐ *File for a NPI if agency does not have one.*

Section Two: Agency Preparation

Chapter 2: General Contractor Responsibilities

How Should A Not-For-Profit Board Prepare For This?

Use this toolkit to educate key staff and Board members. Start with staff leaders (financial, billing, clinical, and administrative) and the Board Finance Committee. You may want to use outside experts to be available for questions of the Board.

The following provides an overview of the operational functions that will be impacted by the shift to managed care:

Operational Function:	Now:	Managed Care Environment:
Referrals	Provider and clinical relationships / SPOA / NYC-HRA	Plans (NOTE: Depends on Plan-type: Medicaid/Medicare/Commercial Role of SPOA has not yet been determined
Billing	eMedNY – regular submission	Each Plan separately with own requirements
Audits	OMIG, OMH	OMIG, OMH, Plans
Quality	OMH	OMH, Plans
Utilization Management	OMH, Medicaid rules	Plan oversight based on State rules and Plan policies
Reporting	OMH, AG – Charities Bureau	OMH, AG – Charities Bureau, Plans

The relationship to the regulators, such as OMH, will also evolve. Currently there is a high degree of interaction due to the flow of clients and the regulatory and payment oversight. Under managed care the rates will be subject to a contract with Plans and much of the interaction related to referrals, approvals and clinical reporting will now be between the providers and the Plans. OMH regulatory oversight will not go away either. Unless there are changes in the programmatic regulations, providers will be required to maintain compliance with all the existing regulations for licensed programs.

Section Two: Agency Preparation

Chapter 2: General Contractor Responsibilities

The Home and Community-Based Services Rule

You should consider introducing your Board to the Home and Community-Based Services (“HCBS”) final rule, which is a new federal standard that may apply to your agency in the future. The rule was finalized in January of 2014; New York State had one year to create a transition plan to address the rule. While it is not yet clear whether community residences will be impacted by the rule, it signals a major new source of federal Medicaid funding that state regulators may wish to tap. One of the key issues in play under the rule is whether a setting is an “institution” versus “community-based.” While there is no strict definition of “community-based,” a number of factors can assess whether a setting is sufficiently community-based to qualify as a proper setting under the rule. Your agency should expect that some of these factors may come into play as the state introduces new Medicaid programs that take advantage of HCBS funding.

These factors determine whether a setting is “community based” versus “institutional”:

- The setting is **integrated**: individuals who receive HCBS there can engage in community life, control their personal resources, and receive services in the community as if they were not receiving HCBS.
- The individual selects the setting from among many options.
- The setting ensures the individual's privacy, dignity, respect, and freedom from coercion and restraint.
- The setting optimizes but does not regiment the individual's initiative, autonomy, and independence in making life choices. The individual can choose daily activities, make choices about his or her physical environment, and choose with whom to interact.
- The setting facilitates individual choice about services and supports, and about the providers of services and supports.
- The individual and the provider have an agreement that sets out eviction and appeal rights.
- The individual has privacy in his or her sleeping or living area.
- Units have lockable doors, and appropriate staff have keys to doors as needed.
- Individuals share rooms only by choice.
- Individuals are free to furnish and decorate their living and sleeping areas.
- Individuals can control their schedules and activities.
- Individuals can access food at any time.
- Individuals can have visitors at any time.
- The setting is physically accessible.

Chapter 2: General Contractor Responsibilities

Homework:

- ☐ *Educate your Board and staff*
- ☐ *Engage staff in understanding the impact on clients (i.e. letters from Medicaid, etc.)*
- ☐ *Educate clients (let them know which Health Plans your organization contracts with)*
- ☐ *Create tracking tools to update Board on progress*

Chapter 3: Pouring the Foundation

Engaging with Managed Care

In order to have the best opportunity to survive the managed care environment there are several activities that can be undertaken with little investment. These activities will also help to clarify how the organization will manage this transition. These are important materials to use when educating your staff and Board.

- *Identify the behavioral health and network development staff at each plan and establish contact.*
- *Develop an agency profile: who are you, what do you do, who do you serve, what is your expertise, outcomes/data (hospitalization rates; community placement rates as examples) and share it with the Plans.*
- *Identify your referral sources, community linkages, and resources.*
- *Identify the internal team to review contracts (don't forget program/clinical staff).*
- **Develop a real cost analysis** of each service you expect to contract for – this means working from current actual costs (Personnel, Client Related, Overhead) so that you can adequately determine what rates will work for your organization.

The last bullet is crucial in order to determine if rates are sustainable for the organization. Since Community Residences will be added to the benefit in 2016 there is time to perform due diligence so that rates are evaluated on the true cost of service and not the historic Medicaid rates which are not reflective of the structure needed for the managed care environment.

Cost modeling represents a particular challenge, given the emphasis on a monthly payment model and no evolved systems for cost-accounting for this industry. Currently the Medicaid payment does not reflect the acuity or complexity of the client, the only relationship between cost and level of service is facility size. Also, the only relationship between revenue and level of service is facility size and property costs. This does not reflect the changing complexity of a client from admission to discharge. OMH is planning to incorporate an assessment process for HARP enrollees that will likely improve the data for client classifications, however in the meantime, managed care organizations are likely to want to move to a per diem rate so that they can better manage costs, utilization and transitions.

Cost-level data is fairly limited for most Community Residences, although annual Consolidated Fiscal Report data represents a key resource for several fixed and indirect costs – “known” data. Alternatively, the “unknown” data (mostly direct costs by individual client) must either be extrapolated from other cost report indicators or gathered via alternative means. The term “Unknown” is used because Community Residences do not have a mechanism to align costs to the actual client diagnosis or complexity.

In order to start a process for getting at “real” cost; your organization should undertake the following:

Chapter 3: Pouring the Foundation

Identify and Quantify the Current Costs or the “Known Data”

- Indirect labor costs (costs for administrative personnel not involved in client care) by individual Community Residence;
- Room and Board costs, i.e. foods, linens;
- Other indirect operating costs – supplies, utilities, etc.; and
- Property – mortgage, bonds, depreciation, interest, taxes, etc.

Understand the Current “Unknown Data”

- Direct labor costs by client diagnosis/complexity - try to track the amount of staff time spent on clients of varying acuity related to medication management time, counseling time, crisis intervention, etc.
- Supply costs by client diagnosis/complexity, if applicable; and
- Outlier cost extremes by client diagnosis/complexity

Gathering Known Data

Fixed operating costs and other “known” data can be found in historical financial operating statements.

Gathering Unknown Data

Gathering the “unknown” data cannot be reliably determined by estimation and there are no defined benchmarks for these areas. You could determine your own per diem costs by data gathered over an initial defined timeframe (e.g., 90-180 days) for selected clients of similar diagnosis/complexity and on a rolling basis thereafter. Cost determinations would be accomplished using a standardized reporting process and data entry logs (for quantifiable and billable costs – such as supplies) and time studies (for direct care labor costs by staff type – if there are differentials such as direct care worker/supervisor/coordinator). Extraordinary or per diem supply costs are typically tracked and billed to your organization and therefore can be identified and also applied to the cost model.

In addition to the actual current client direct costs and overhead, under managed care there will be addition costs for necessary improvements such as: Information Technology (IT), billing, data collection and reporting. The cost of updating billing systems (the need for automated billing to Plans will be critical to cash flow) and improving IT to assure the billing and reporting to multiple Plans will need to be analyzed. Those estimated costs should be included in any cost modeling.

Although the State has developed a policy to stabilize rates, providers need to be aware of all the issues related to rates. The State plans to require the Plans pay a “transitional rate” to providers for two years, which is anticipated to be the government rate for each provider at the time of the transition to Medicaid managed care. This policy only applies to Medicaid.

Section Two: Agency Preparation

Chapter 3: Pouring the Foundation

In addition you want to make sure that the contract language is clear that the transition rate covers all clients during the 2 year period not only clients that were in house at the time Community Residence became part of the benefit package. In other transitions of Medicaid programs to managed care, Plans negotiated lower rates for “new to service” individuals which overtime became the defacto rate for all clients. ACL will work with OMH during 2015 to understand how the 2 year guaranteed rates will be calculated. ACL does NOT believe that merely extending existing rates at the time of transition is a reasonable policy.

Referrals and occupancy rates will become critical indices for providers to track. After the transition, and even during the two year period, Plans may direct new referrals to lower cost providers. Therefore, effective communication with the Plans about your bed availability with quick response times will be critical to your ability to be competitive, ultimately affecting your cash flow. In addition, it will be important to track your occupancy by Plan.

Although occupancy factors are considered in the current OMH Medicaid rate setting; Plans will be unconcerned about your occupancy until they want access for an enrollee. Understanding and tracking key information about referral trends and occupancy by Plan can inform evaluation of each Plan contract in the future, or even prompt discussion about bed guarantees.

Homework:

- ☐ *You do want to understand if Medicaid based rates are adequate to meet all the requirements of the contract.*
- ☐ *Plans that are approved by the State to provide HARP coverage are required to have network and clinical staff with behavioral health expertise. You should ask to speak with those individuals before signing any contract. Creating relationships with the staff responsible for behavioral health services within the Plan (whether a HARP or MMC) is a good strategy.*
- ☐ *If a BHO approaches your organization, request the list of Plans that have contracts with the BHO. Since the BHO can be acting on behalf of a Plan you should understand which Plans are involved.*
- ☐ *Plans are already developing networks. They are aware of the State policy on transitional rates. You are encouraged to discuss this with Plans prior to the transition of Community Residence into the benefit package.*
- ☐ *Educate your Board — understanding the real costs may result in increasing expenditures for such items as: IT, billing support, staffing, etc.*

Section Two: Agency Preparation

Chapter 4: Contracting

Background

Many different entities may begin to approach mental health providers, including Community Residences, in New York State as Medicaid moves to a managed care model, and behavioral health benefits under private, commercial plans become more generous under the Affordable Care Act. Providers should be familiar with the whole range of these entities.

Health Plans

As you know health plans can offer many different **Coverage Plans** to employers or individuals who want to buy health insurance. Those different coverage plans are sometimes known as different “**products**” or “**product lines**.” Insurance companies may have **Medicaid** as one product line, and privately-paying **Commercial**, or Medicare as different product lines. For example, Health Plan A may offer a Commercial PPO to businesses, but may also develop a Medicaid Managed Care Plan that the State of New York must approve. The same Health Plan can offer these very different products. Behavioral health providers should be prepared to evaluate contracts with Health Insurance Companies that cover Medicaid coverage plans, as well as commercial coverage plans. Health Plans will probably include all products and coverage plans they offer in the contract. The contracts that they offer you will say which coverage plans they want you to become part of, but you should do your own research to find out what coverage plans the health plan offers, and how to best evaluate your rates for those plans. You can find a list of all Health Plans and their Coverage Plans by County in the appendix.

Managed Care Organizations (“MCOs”)

A managed care organization is a health plan that offers managed care coverage plans, and may offer Medicaid Managed Care coverage plans. The State of New York will pay the MCO a certain amount for each Medicaid beneficiary enrolled in the MCO’s coverage plan. In turn, the MCO pays its providers based on rates that the MCO negotiates with those providers. To qualify as a Medicaid MCO, the MCO must have a network of health providers—behavioral and physical—that is sufficient to take care of its beneficiaries. Although Medicaid MCOs may be required to guarantee previous Medicaid rates to certain providers for a specified period, Medicaid MCOs will eventually be able to negotiate freely with the providers in their networks.

Independent Practice Associations (“IPAs”)

A group of providers, including behavioral health providers, can choose to sign agreements that join them into a collective, called an IPA. Not all IPAs are provider-owned groups; some have contracts with Managed Care Organizations to do things that MCOs would otherwise do for themselves. Consult the IPA Memorandum in the Appendix to learn more about the various kinds of IPAs. In theory, IPAs negotiate with plans on behalf of their members. There are pros and cons to joining IPAs, and the details about IPAs vary depending upon the contracts that the members sign. Providers should be aware that joining an IPA can limit what direct negotiating they can do with insurance companies, and termination of the relationship may also be cumbersome. Unfortunately, you may sometimes see a contract that looks like it comes from a health insurance plan, but really comes from an IPA—and that IPA may not function like the collective bargaining tool that a traditional IPA. Again, review

Section Two: Agency Preparation

Chapter 4: Contracting

the IPA Memorandum in the Appendix to learn more about the different varieties of IPAs. If you can't tell right away who the other party is in a contract, you should seek help and look for information about the other party.

Behavioral Health Organizations (“BHOs”)

A BHO is an entity that asks behavioral health providers to join its network, and then negotiates directly with health plans to offer behavioral health services to those health plans. BHOs can try to develop networks that they then shop around to health plans, or they may work with health plans and then seek out providers to join their network. Plans may like to work with BHOs because BHOs may have more experience with behavioral health than health insurance companies. BHOs may have already assembled networks of behavioral health providers, something that would take the health plan some time to do on its own. Keep in mind that joining a BHO means that a provider will be working under the BHO's rules, and often the rules of any insurance plan the BHO works with. This means that you might have to deal with two sets of policies and procedures, and two sets of staff at different organizations in order to be paid for your services. This all depends upon the terms of the agreement with the BHO.

Any of these organizations may approach your agency with a contract that looks something like the sample contract we have included in this Toolkit, although you will probably see a document that is longer, and that includes attachments, exhibits, or appendices. We have included samples of some of the most important provisions in these kinds of contracts. These sample terms are overwhelmingly favorable to “The Insurer,” and often very unfavorable to you, “The Provider.” We have described what the terms mean, and why certain terms are good or bad for you, but this is no substitute for examining every contract that you are given carefully. You should ask clinical, administrative, and program personnel to review these contracts—you may find that your current practice is totally incompatible with what a contract asks you to do. You should read these contracts from front to back, and start to become familiar with the way they sound. You should also seek the advice of a lawyer if you have any questions about the agreement, or if you are uncomfortable with what you are reading.

Chapter 1: The Contract

Sample Managed Care Agreement

*This is a sample of just a few of the most important terms that are typically part of a managed care agreement. You should seek out these sections whenever you review a contract from an insurance company: a description of the **services, rate, term and renewal, policies and procedures, claims submission process, payment process, termination, continuity of care, post-termination, appeals and grievances, and arbitration.** The entire contract should be closely reviewed. The following are examples, your contract may look different.*

SAMPLE MANAGED CARE AGREEMENT

This Agreement is made and entered into by and between THE PROVIDER and THE INSURER and is effective as of the date on the signature page of this Agreement. In consideration of the mutual promises and consideration herein, the sufficiency of which is hereby acknowledged, the parties agree as follows:

1. **THE PROVIDER** agrees to provide mental health, alcohol abuse, or substance abuse (“Covered Services”) for which THE INSURER’s members are covered under a plan.
2. **Rate.** THE PROVIDER agrees to accept payment for Covered Services in the amounts listed in the Rate Schedule attached to this Agreement and incorporated herein by reference.
3. **Term & Renewal.** The term of this Agreement shall be for a period of one year beginning on the effective date on the signature page of this Agreement. The term will renew automatically for additional one year terms unless either THE PROVIDER or THE INSURER notifies the other party sixty days before the end of the agreement that the Agreement will not be renewed, or this Agreement is terminated for some other reason specified in this Agreement.
4. **Policies and Procedures.** THE INSURER maintains a Handbook (or Provider Manual) and may, from time to time, institute other policies or procedures that THE PROVIDER agrees to follow. THE INSURER will post its most-current Handbook, policies, and procedures to its website.
5. **Claims Submission.** THE PROVIDER shall submit all claims to THE INSURER by electronic means using the 837 format under 45 C.F.R. § Part 162. THE PROVIDER shall submit claims that are complete and accurate, using the National Provider Identifier and including proper CPT or HCPCS coding. THE PROVIDER shall submit claims within 90 days from the first date services are rendered. THE INSURER shall not be obligated to pay any claim that THE PROVIDER submits later than 90 days from the first date services are rendered. THE INSURER shall not reimburse THE PROVIDER for any claims that do not conform to this section. THE PROVIDER agrees not to bill THE INSURER’s members for services rendered beyond any copayment, deductible, or coinsurance payable to THE PROVIDER.

Chapter 1: The Contract

6. **Payment of Claims.** Upon receiving reasonably clear and undisputed claims that meet the requirements of Paragraph 4, THE INSURER will make payment to THE PROVIDER within 45 days of receiving the claim. THE INSURER may retroactively adjust or recalculate payments it makes to THE PROVIDER, make additional payments to THE PROVIDER, or collect or retain sums from future payments to THE PROVIDER in some circumstances. These include, but are not limited to, member enrollment or eligibility, utilization review, or inaccurate or incorrect billing at any time.
7. **Termination.** THE INSURER may terminate THE PROVIDER with sixty days' written notice if THE INSURER determines that THE PROVIDER's quality of care, utilization management, billing practices, or cooperation is unacceptable.
8. **Continuity of Care.** In no event, including, but not limited to, nonpayment by THE INSURER, insolvency of THE INSURER, or breach of the Agreement, shall THE PROVIDER charge THE INSURER's members for services provided under the Agreement. In the event of insolvency of THE INSURER, PROVIDER will continue to provide benefits to THE INSURER's members for the duration of the members' contracts with THE INSURER for the period for which premiums have been paid. The provisions of this section shall survive any termination of the Agreement.
9. **Post-Termination.** If THE INSURER terminates THE PROVIDER for any reason, THE PROVIDER agrees to provide Covered Services at the rates set out in this Agreement and under the requirements of this Agreement until (a) THE INSURER's member has completed his or her course of treatment, (b) until THE INSURER arranges for another provider to render care to the member, or (c) ninety days, whichever is the lesser.
10. **Appeals & Grievances.** THE PROVIDER may appeal denials of claims submitted to THE INSURER. THE PROVIDER must appeal in writing, within sixty days of the date of the denial, following the procedures set out in **The Insurer's Handbook**. THE PROVIDER must follow the procedures set out in THE INSURER's Handbook for all appeals and grievances that arise out of this Agreement. THE INSURER's Handbook is incorporated herein by reference.
11. **Arbitration.** THE INSURER and THE PROVIDER agree that the exclusive remedy for any dispute that arises out of this Agreement shall be binding arbitration. The parties shall assume their own costs, including attorneys' fees, and shall bear the cost of the arbitration proceeding equally.

Section Three: Dissecting The Contract

Chapter 2: The Insurer

The Insurer

This Agreement is made and entered into by and between THE PROVIDER and **The Insurer** and is effective as of the date on the signature page of this Agreement.

Know who you're talking with. The insurer may actually be an independent practice association ("IPA"), or maybe even a behavioral health organization ("BHO"), a contractor who does work with insurance companies. The name of the entity may not really tell you who you're dealing with. A web-based search for the name on the contract will help.

Don't rely on what you hear from the person who is giving you the contract. That person probably did not write the agreement, and may not understand it. In either case, that person may not have your organization's—or your clients'—best interests at heart. Use this Toolkit to learn as much as you can about the insurer you are dealing with. Where are they located? Do they have lots of enrollees, or only a few? This kind of information will help you to understand why the insurer has approached you, and give you a sense of how valuable you are to them. This, of course, helps you to engage with the plan.

Homework:

- ☐ The contract clearly identifies the insurance company.
- ☐ The insurance company's size, geographic reach, and available plans have been investigated.
- ☐ It is clear why this insurance company approached my agency.
- ☐ All appropriate staff, including finance, program, clinical, and administrative personnel have reviewed the contract.
- ☐ Review IPA memo in Appendix

Section Three: Dissecting The Contract

Chapter 3: Services

Covered Services

THE PROVIDER agrees to provide mental health, alcohol abuse, or substance abuse (“Covered Services”) for which THE INSURER’s members are covered under a plan.

Coverage standards for beneficiaries with behavioral health needs has expanded under the Affordable Care Act. This means that insurance companies that offer both Medicaid plans and private, commercial plans may want to include behavioral health providers in both the plan’s Medicaid and the commercial networks.

Providers should take these opportunities to identify every service that they provide. Because these plans may be new to offering behavioral health services, this is a good time to demonstrate that the services you offer keep people healthy and safe, and can ultimately keep costs down for the plans; remember that plans are always looking for ways to keep their costs down by avoiding inpatient hospitalizations or higher cost services. The plans must meet certain outcome measures and look for partners that can support such outcomes.

Even if some of the services you offer are not Medicaid benefits, you should lay the groundwork with these plans for eventually entering their commercial plan networks for the services you do offer.

Homework:

- ☐ *The contract lists every service that the agency provides*
- ☐ *The contract does not list any service that the agency does not provide*
- ☐ *If the contract does not include some of the agency’s services, the agency’s representative has asked to include these in the agreement*

Section Three: Dissecting The Contract

Chapter 4: Rate

Rate

THE PROVIDER agrees to accept payment for Covered Services in the amounts listed in the Rate Schedule attached to this Agreement and incorporated herein by reference.

This is a critical part of the agreement. If the rate is not adequate to cover your expenses, then you should not accept it. Often, these agreements do not include rates, and you may be told that the rate schedule is coming. Don't sign an agreement without a rate included.

Medicaid Managed Care Plans have to offer the previous Medicaid rate for a certain time as behavioral health transitions to managed care in New York. However, you should be aware that the health insurance companies that offer Medicaid Managed Care Plans may also have commercial health plans that will need to offer behavioral health benefits too. You do not have to accept your Medicaid rate for those commercial plans.

You should also be aware that if your Medicaid rates is low—or if the rates of other providers in the area are low—the Plans will pressure you to accept low rates for Medicaid once they are no longer required to pay certain rates.

Even if the insurer does have to guarantee a rate for some period of time, this is an opportunity to seek rates that cover the real cost of providing your services. Focus on the rate that represents the true cost of the services you provide.

Having an actual number that reflects the cost of what you provide—room, board, personnel, administrative expenses, utilities, cleaning services, telephone services, and so on—will strengthen your ability to document this for plans. Remember that accepting a low rate is just half the equation; the plan also controls referrals so accepting a low rate without certainty for referrals can result in significant loss of revenue.

Homework:

- ☐ *It is clear how much it costs the agency to provide the services for which the insurer is looking to contract.*
- ☐ *There are rates included with the agreement.*
- ☐ *The rates meet or exceed the agency's costs.*

Section Three: Dissecting The Contract

Chapter 5: Term & Renewal

Term & Renewal

The term of this Agreement shall be for a period of one year beginning on the effective date on the signature page of this Agreement. The term will renew automatically for additional one year terms unless either THE PROVIDER or THE INSURER notifies the other party sixty days before the end of the agreement that the Agreement will not be renewed, or this Agreement is terminated for some other reason specified in this Agreement.

You should expect that your term will be a year, and you should expect that the contract will automatically renew. It should be an important part of how you manage the contract. If you accept an agreement, you should be evaluating how the contract works for you at least three months before the end of the term.

You should set aside time three months before the contract ends to look at all the information. Evaluate how the contract is working from day one, and then plan claims and any appeals. Are many claims denied? Do you and your staff have to appeal claims? Does the insurer treat patients or clients? Tracking over the course of your contract is important.

If it becomes clear that you're spending a lot of administrative time on this insurer, or that your rate just does not reflect your costs, you should be prepared to contact the insurer to renegotiate your rate, or give your 60 days' notice to terminate. Be aware that even if you terminate the agreement, you may still have to take care of patients who are insured by the insurer for a period of time. You must know in advance if you will be paid for that care under the rules and rates of your now-terminated contract.

This section should be used as opportunity to review activities and determine what issues need to be discussed with the plan and make a decision about whether to renew the contract for a subsequent year.

Homework:

- ☐ The start and end dates for this agreement are clear.
- ☐ The agency staff understands when to tell the insurer that the agency is terminating the agreement.
- ☐ The agency has set up a way to keep track of the claims the agency submitted, the claims denied, and the payments received under this contract.
- ☐ The agency has a process to review this agreement monthly and before it must tell the insurer that it is terminating the agreement.

Section Three: Dissecting The Contract

Chapter 6: The Insurer's Handbook

Many insurers have a policy manual or handbook that tells providers how to submit claims, appeal denied claims, file grievances, or do practically anything else that falls under the agreement. This handbook may not be included with the contract that you sign, but request a copy and review it before you sign, some may be accessible online. The procedures in the handbook may say that you need to use certain software, for instance, to submit claims, or may set different standards for sending paper claims. When you sign an agreement that talks about the handbook in this way, the handbook is part of the contract, and you should review it before you sign.

Homework:

- ☐ *The agency has a copy of the insurer's handbook.*
- ☐ *The agency understands the process in the insurer's handbook.*
- ☐ *The agency understands when and how the insurer's handbook will be updated*

Section Three: Dissecting The Contract

Chapter 7: Policies and Procedures

Policies and Procedures.

THE INSURER maintains a Handbook and may, from time to time, institute other policies or procedures that THE PROVIDER agrees to follow. THE INSURER will post its most-current Handbook, policies, and procedures to its website.

The agreement may not be specific about all of the things you need to do—it may say that that it requires you to follow its policies and procedures. Some agreements do not specify the insurer to tell you it has changed its policies, procedures, or Handbook—you and your staff may have to seek out that information and make sure it has not changed.

This could mean that you have to spend staff time checking the status of the policies. If the procedure for submitting claims changes, for example, your claims may be denied if your staff does not know that there are new policies in place. You should ask for a copy of the policies that will apply to you. You should review this material to make sure you have the kind of staffing power to handle these requirements. These costs should be a factor in the rate.

Ask the insurer to notify you ahead of time that it has changed its policies, or updated its Handbook. In any case, the Handbook or policies in place at the time you file a claim should govern that claim. If the insurer must notify you about changes to its policies, this will lessen the likelihood of disputes. This will also help ensure that your claims are processed without delays.

The sample language used is too vague. Good language will require the insurer to give you notice when the policies and procedures change, or even provide you with those documents when they change.

Homework:

- ☐ *The agency understands when and how the insurer's handbook and policies and procedures will be updated.*
- ☐ *The agency has asked for all policies and procedures that apply.*
- ☐ *The agency has identified staff to become familiar with these policies, procedures, and handbook.*

Section Three: Dissecting The Contract

Chapter 8: Claims Submission

Claims Submission.

THE PROVIDER shall submit all claims to THE INSURER by electronic means using the 837 format under 45 C.F.R. § Part 162.1 THE PROVIDER shall submit claims that are complete and accurate, using the National Provider Identifier and including proper CPT or HCPCS coding. THE PROVIDER shall submit claims within 90 days from the first date services are rendered. THE INSURER shall not be obligated to pay any claim that THE PROVIDER submits later than 90 days from the first date services are rendered. THE INSURER shall not reimburse THE PROVIDER for any claims that do not conform to this section. THE PROVIDER agrees not to bill THE INSURER's members for services rendered beyond any copayment, deductible, or coinsurance payable to THE PROVIDER.

The agreement likely sets strict standards that must be met when submitting claims. You may be required to submit your claims electronically and meet certain formats. You should be sure that you have this capability before you sign the agreement. If you do not already submit claims in this way, or do not have staff familiar with doing so, you should factor the cost of buying this software, training staff, and possibly hiring staff or contracting out to perform billing. Keep in mind that each plan may have a different standard for submitting claims, and your billing must conform to each standard.

The time limit for submitting claims is often strict. You will want a system in place to ensure that you bill the insurer on a monthly basis. Reviewing your current FFS process is a place to start to understand if it can be more efficient..

Bear in mind that the insurer may simply deny claims that are late—even if there is a good reason that they are late. You can always appeal under the contract, but it is worth considering the impact of billing standards on your operations..

Providers who do not use electronic billing software, or who are unused to billing providers other than Medicaid, will find that terms require them to invest in new technology and training. Insurers prefer electronic billing, and will often pay more slowly on paper claims. A careful review of this term will assist in determining the resources necessary to meet the standards set out in the contract.

¹ 837 format is a term that describes the way to submit electronic data to an insurer. The HIPAA regulations set these standards. See 42 C.F.R. § 162.920. You may wish to contact one or several billing software vendors to procure billing software that can perform in the way your contracts require them to perform.

Chapter 8: Claims Submission

Homework:

- ☐ *The agency has the technology needed to submit claims under this agreement.*
- ☐ *Agency staff is trained so that they can submit claims under this agreement.*
- ☐ *The agency has enough resources to submit claims under this agreement.*
- ☐ *The costs of training, software, and personnel necessary to submit claims under this agreement are included in the rate.*

Section Three: Dissecting The Contract

Chapter 9: Payment of Claims

Payment of Claims.

Upon receiving reasonably clear and undisputed claims that meet the requirements of Paragraph 4, THE INSURER will make payment to THE PROVIDER within 45 days of receiving the claim. THE INSURER may retroactively adjust or recalculate payments it makes to THE PROVIDER, make additional payments to THE PROVIDER, or collect or retain sums from future payments to THE PROVIDER in some circumstances. These include, but are not limited to, member enrollment or eligibility, utilization review, or inaccurate or incorrect billing at any time.

Pay close attention to the timeframes set out in the contract. If you waited until the last day to submit a claim (90 days) payment will not occur for 45 days. Meaning that your receivable for the claim is over 120 days. This is why assessing ability to submit claims quickly is critical. Typically FFS providers are accustomed to billing and receiving payments on a biweekly basis.

Be aware that most agreements include language that allows insurers to claw back payments already made, or withhold future payments, for many reasons—including the eligibility of their member for insurance. This should underscore how important it is to ensure that the person you are caring for is really a member of the plan eligible for services. Your intake procedures must reflect this consideration, or else you may end up rendering care for free.

Clawbacks will probably happen in this way: you will expect a payment from the insurer for claims you have submitted, and you will see that the amount “clawed back” for whatever reason is subtracted from whatever you are owed. This can seriously alter your cash flow, and you should be aware that the insurer may not just ask you for a refund, but can take what they say you owe them out of your next payment. It will be important to understand billing standards as well as verifying client eligibility of both Medicaid as well as enrollment in insurer plans.

This can be a risk for providers. The insurer has the power to take back what they have paid days, weeks, months, and possibly even years down the line. Providers should look for terms that are specific about when and why insurers can take back payments, and limits on those exposures. This term should also be read in the context of how appeals and grievance procedures work.

Chapter 9: Payment of Claims

Homework:

- ☐ *All of the ways that the insurer can take back or withhold payment of our claims are clearly defined.*
- ☐ *The agency has process to manage receivables by plan.*
- ☐ *The agency has a process to keep track of the insurer withholds or clawbacks.*
- ☐ *The agency has a plan to enact internal controls to protect against denied and clawed back claims.*
- ☐ *The agency has a plan to enact immediate responses to denied, withheld, and clawed back claims.*

Section Three: Dissecting The Contract

Chapter 10: Termination

Termination

THE INSURER may terminate THE PROVIDER with sixty days' written notice if THE INSURER determines that THE PROVIDER's quality of care, utilization management, billing practices, or cooperation is unacceptable.

The agreement may give the insurer very broad ability to terminate you as a provider, and sometimes the criteria may be very vague. Termination may be insurer oriented. You should look to protect your organization. You want to know exactly what you have to do to meet the insurer's expectations related to billing, outcomes, reporting and utilization management. You do not want to be blind-sided by a termination that then saps a referral source for you and disrupts your clients.

This language is not favorable for most providers. You should look to have clarity about this specific term and how to manage any notice of termination. This gives the insurer the complete right to determine something is "unacceptable," but does not say what, exactly, would be unacceptable. Something specific that you can prevent and measure might be acceptable.

Homework:

- ☐ *It is clear how much notice the insurer has to give the agency if it decides to terminate the agreement.*
- ☐ *All of the reasons the insurer can use to terminate the agreement are clear.*

Section Three: Dissecting The Contract

Chapter 11: Continuity of Care

Continuity of Care

In no event, including, but not limited to, nonpayment by THE INSURER, insolvency of THE INSURER, or breach of the Agreement, shall THE PROVIDER charge THE INSURER's members for services provided under the Agreement. In the event of insolvency of THE INSURER, PROVIDER will continue to provide benefits to THE INSURER's members for the duration of the members' contracts with THE INSURER for the period for which premiums have been paid. The provisions of this section shall survive any termination of the Agreement.

While it may seem unlikely that the insurer will become insolvent or go out of business, the insurer could always violate your agreement in some way, and fail to pay you. You may have to go through arbitration to eventually be paid what you're owed. This can take some time, and in the meantime, you may be providing uncompensated care for clients who belong to the insurer's plan. Even if your client then changes coverage plans, the plan in place when your client receives care is the only entity you can bill for your services.

This language can be very troubling for providers, because your payment is threatened. This is why learning about the insurer you are dealing with is so important—you want to know that the company is a good one, and one that will not become insolvent.

Sometimes, the insurance company may cease to exist after you sign a contract with the company. It may be that the insurance company is unable to pay you for your services. This contract requires you not to bill your clients for their care as this is a requirement of Federal law for Medicaid and Medicare as a protection to beneficiaries. You may be left providing services without payment in this case. Your client will continue to receive care, and it is likely that your client will change coverage plans. Nonetheless, you may be left providing uncompensated care for the time between the insurer's insolvency and your client's change to a new plan.

Homework:

- ☐ *It is clear to agency personnel that if the insurer dissolves or does not pay the agency, we cannot bill the client for services rendered.*
- ☐ *It is clear that the agency may be left without payment for its services if the insurer cannot pay.*

Section Three: Dissecting The Contract

Chapter 12: Post-Termination

Post-Termination

If THE INSURER terminates THE PROVIDER for any reason, THE PROVIDER agrees to provide Covered Services at the rates set out in this Agreement and under the requirements of this Agreement until (a) THE INSURER's member has completed his or her course of treatment, (b) until THE INSURER arranges for another provider to render care to the member, or (c) ninety days, whichever is the lesser.

If an agency terminates the agreement, these agreements nearly always require you to continue to provide care to members of an insurer—and to do so following the same rules and for the same amount of money. The insurer will continue to pay for your services for the amount of time the contract requires, but will only pay at your old rate. In this agreement, you may be stuck with that old rate for as long as 90 days. This is another reason why understanding your costs and their impact on rates is so important. Even if you do terminate the agreement and possibly renegotiate with this insurer, you are stuck with the rate you initially had, sometimes until that person leaves your facility.

This language, just like the Continuity of Care term, is troubling for providers, but probably something the insurer will not negotiate. You could suggest a limit on the number of days you will have to provide care for a client on a plan that terminated with you (or that you have terminated) to the lowest number. Ninety days may be too long depending on the agency's typical program, occupancy and turn over.

Homework:

- ☐ *The agency has a procedure to track clients by insurer.*
- ☐ *The rate in this agreement is high enough that the agency can cover its costs one year or more from now, even after the agreement is terminated.*

Section Three: Dissecting The Contract

Chapter 13: Appeals & Grievances

Appeals and Grievances.

THE PROVIDER may appeal denials of claims submitted to THE INSURER. THE PROVIDER must appeal in writing, within sixty days of the date of the denial, following the procedures set out in THE INSURER's Handbook. THE PROVIDER must follow the procedures set out in THE INSURER's Handbook for all appeals and grievances that arise out of this Agreement. THE INSURER's Handbook is hereby incorporated herein by reference.

The appeals process is very important to understand. Insurers can deny claims that are valid; the provider's responsibility is to appeal these denials. Some insurers use algorithms to deny certain claims. Remember that a human being may not reviewing your claim at first. You need to become an advocate for the agency, pay careful attention to the claims you submit, and appeal denials in a timely fashion. In any agreement you sign, understand that resources to appealing claims are necessary.

Often the details and procedures for appeals are set out in the Handbook. Get copies of handbooks and read them closely to determine whether the appeals procedure is fair, and if it is possible for you to comply with it.

Homework:

- ☐ *A copy of the insurer's handbook has been obtained.*
- ☐ *Agency staff understand the process in the insurer's handbook.*
- ☐ *Agency staff understand when and how the insurer's handbook will be updated.*
- ☐ *Someone has been trained to understand the appeals process for claims.*
- ☐ *Someone is tracking appealed claims.*

Section Three: Dissecting The Contract

Chapter 14: Arbitration

Arbitration.

THE INSURER and THE PROVIDER agree that the exclusive remedy for any dispute that arises out of this Agreement shall be binding arbitration. The parties shall assume their own costs, including attorneys' fees, and shall bear the cost of the arbitration proceeding equally.

Expect to see an arbitration clause in contracts with insurers. Avoiding an agreement that is unclear or unacceptable can reduce the exposure to living with a bad contract or going to arbitration—which will cost you even if you win. Any legal remedy will involve costs; arbitration can be one of the less expensive remedies, but it is very difficult, if not impossible, to appeal a bad decision. The arbitration clause should be a reminder to you that this agreement needs to be as good, and as clear, as possible.

Also, as health care programs become more complicated, be aware that the arbitrator you use may be unfamiliar with your agency, your regulator, and even the ins and outs of Medicaid Managed Care. Arbitration can also be very expensive, and some arbitration clauses limit the provider's ability to get records from the plan on a claim. Be aware that your agreement may list arbitration terms that are very unfavorable, and that may put your agency at a serious disadvantage if you do go to arbitration.

Homework:

- ☐ *It is clear whether there is an arbitration requirement in the contract.*
- ☐ *It is clear that the agency may have limited or no ability to appeal a negative decision in arbitration.*

Section Four: Project Reporting for the General Contractor

Chapter 2: What Your Board Can Do To Help During The Transition

The Board needs to understand that the transition to managed care in this industry is a seismic shift that changes how you are paid for your services. Agencies entering need to be smart and undergo careful planning going forward.

Commercial Insurance Plans

Although the transition to Medicaid Managed Care is approaching rapidly, and may seem like the most pressing issue before your agency, the fact that commercial, privately-paid insurance plans must now offer behavioral health coverage under the Affordable Care Act may have a longer-term impact on your business. People who had coverage but never thought they could afford or be eligible for behavioral health care may begin looking to take advantage of their benefits. Health insurers may start investigating ways to keep their members healthy and safe to avoid the high costs of psychiatric inpatient stays, and promote long-term recovery for their members. Behavioral Health providers should be prepared for these commercial plan inquiries, and should not lose sight of this development in the immediate transition to managed care in Medicaid.

A Lesson Learned About Working with Insurance Plans

Physicians and other health care providers have been working with managed care plans for many years now, and there are some lessons to take away from their experiences. Always remember that managed care companies reduce costs by sending their members to “in-network” providers—those health care providers who have contracts with the managed care company at a certain rate. Managed care companies do not like their members to see out-of-network providers, who do not have contracts with the managed care companies and can charge their customary, often higher, rates. To keep costs down Managed care companies will discourage their in-network providers from referring members to out-of-network providers. If you are in a network, expect that the plan will expect that you send your clients to in-network providers—and expect that you may need to defend your decisions about your referrals. This also means that if you decide not to join an insurer’s network, your referral sources may not refer to you. Your duty is always to your clients, and their best interests, and this can sometimes conflict with a managed care company’s plan to keep referrals in their networks. Understanding which providers are in-network is key to relationship building.

It All Comes Back to Your Mission

Mission-driven organizations will find it easy to see why it is important to enter the marketplace fully informed and ready to negotiate: if you can’t get rates that pay your costs, your organization will be unable to survive in the longterm. If your organization takes on agreements with insurers that are not true partners, your clients could feel the effects.

Your organization’s mission may require you to strike the best agreement that you can with an insurer—at fair rates that pay your expenses, with reasonable provisions that allow you to do your job without spending too much time on administrative work, consistently enough

Chapter 2: What Your Board Can Do To Help During The Transition

that your day-to-day operations can run smoothly and outcomes for clients are of high quality. Your contracts with insurers determine whether any of this can happen.

Your organization's directors have a duty to pay attention and manage the transition to managed care.

In New York, Section 717(a) of the Not-for-Profit Corporation Law says that "[d]irectors and officers shall discharge the duties of their respective positions in good faith and with the care an ordinarily prudent person in a like position would exercise under similar circumstances."

Your agency runs a business—although you are a nonprofit organization, you provide a service in exchange for a fee. So remember:

- No business would sign an agreement with an entity that can control its income without identifying concerns and seeking redress first.*
- No business can accept a payment for less than its services are worth and expect to be sustainable.*

Section Four: Project Reporting for the General Contractor

Chapter 2: What Your Board Can Do To Help During The Transition

Negotiate From Information

In most instances, the current rates do not adequately compensate your agency for the work it does now. You need to analyze costs to determine how much the services actually cost. This information is critical to present to Plans so that the relationship is long-term for both parties. If you have 5 or more Medicaid recipients, Plans must have you in their network.

You also need to know what Plans are out there and what they may want from your agency. You should understand which plans may come knocking because of your current client base and which ones have a good reputation.

Get the Best Rates

The Medicaid rate, while a base for 2 years, is probably not sufficient in the long term. It not in your own, or your clients', best interest to agree to a contract without trying to get the best rates for your agency.

Vet the Plans and Contracts Thoroughly

Not all managed care contracts are the same. The contracts themselves can have requirements that are impossible to accommodate. Using key administrative, clinical and financial staff to review the contracts is critical to making good decisions and implementing the changes needed.

Empower the Right People

Every contract with an insurer should be evaluated from three angles: program, financial, and operational. A team of people who have the kind of training they need to judge a contract in each of these areas should be assembled, and that team should review contracts. These people should be able to recommend action on contract to the appropriate authorities.

Prepare for Financial Transition

Payment processes will change dramatically. Currently monthly rates may be the norm, but you should expect that insurers may offer you daily rates. You should expect that the time you put into submitting claims will delay your payment. If you are offered daily rates, you should become very familiar with the Policies and Procedure manuals, so that you can understand how frequently you should submit claims. It's likely you will bill more frequently than you do now—hospitals, for instance, typically bill daily. You should expect that there may be questions from an insurer about whether or how much to pay you. Your organization's cash flow is likely to change. If your organization has a Finance Committee,

Chapter 2: What Your Board Can Do To Help During The Transition

for example, you should take some time to explain this new reality to that Committee and potentially plan for infusion of working capital during the transition.

Invest Where Necessary

The agency may need to hire new personnel, or train current staff. The agency may need to buy new information technology to write and submit claims and keep track of payments and submissions. These are not optional expenses.

Chapter 4: What Makes A Health Plan Good or Bad?

Your Board Needs Regular Progress Reports During the Transition

Set deadlines for Board Review of activity at several points during preparations for the transition. Create a plan to gather the information needed to transition effectively, and set deadlines for reporting this information to the Board. Ask yourself these questions:

- Have the health insurers in our area been evaluated?*
- Have actual costs been assessed?*
- Is our team assembled to review the contract?*
- What is/are their reviewing standards for the contract?*
- How are their findings reported to the Board?*

Section Four: Project Reporting for the General Contractor

Chapter 4: What Makes A Health Plan Good or Bad?

What Makes a Health Plan or Coverage Plan Good or Bad?

No one factor makes a Health Plan, or the Coverage Plans it may offer, good or bad—whether it is good or bad for your agency depends primarily on these factors:

Rates

Do they pay you what it costs to actually provide the service?

Timely Payment

Do they pay your claims in a timely fashion? If you do not have history working with them, does the Health Plan have a reputation for paying claims in a timely fashion? This is where you may want to ask other kinds of providers who do work with those Health Plans, as they have experience with these kinds of plans. Reach out to your network.

Clawbacks

Do they take back payments after the fact for reasons beyond your control? Again, if you have never worked with this Health Plan, it is worth gauging its reputation on this point.

Clear and Easy Communication

Is there someone at the Health Plan who manages your relationship, who you can call and easily reach, who provides you information when you need it? When you need to confirm eligibility, make a claim, make an appeal, or even just ask a question, you should know who to talk to and how.

You should bring these concerns up in discussion with the Plan before you sign. Waiting until after signing to identify concerns is not likely to result in changes.

How Does This Affect My Clients?

Your clients may be in Plans you don't have a contract with. Those Plans may engage in practices that are difficult.

Medicaid Plans are required to contract with providers who are caring for 5 or more of the Plans' Medicaid members. However, you don't have to join a Plan just because one or two of your clients are in the Plan. Your clients may choose to change Plans to be part of Plans you are in.

You can let your clients—and referral sources—know what Plans you participate in, and which ones you don't. This can help.

Your clients may have out-of-network benefits. How do those work?

- *Find out what Plan your clients are enrolled in.*
- *Call the phone number provided and ask whether your services are covered.*

Section Five: Resources

Chapter 1: New York Comprehensive Environmental Scan

County	Plan Name	Medicaid Managed Care	Family Health Plus	Medicaid Advantage	Medicaid Advantage Plus	Managed Long Term Care	Commercial
Albany	TOTALS:	31,788	2,348	238	51	343	-
	Capital District Physicians Health Plan	21,627	1,337	-	-	-	-
	Eddy Senior Care	-	-	-	-	3	-
	ElderPlan	-	-	-	-	6	-
	Fidelis	-	-	124	-	-	-
	Fidelis Care at Home	-	-	-	-	104	-
	NYS Catholic Health Plan	8,137	860	-	51	-	-
	United Healthcare Plan of NY	271	24	-	-	5	-
	VNA Homecare Options	-	-	-	-	39	-
	VNS Choice	-	-	-	-	148	-
	Wellcare of New York	1,753	127	114	-	38	-
Allegany	TOTALS:	5,509	422	-	-	18	-
	HealthNow	3,086	197	-	-	-	-
	NYS Catholic Health Plan	538	51	-	-	-	-
	Total Senior Care	-	-	-	-	18	-
	Univera Community Health	1,885	174	-	-	-	-
Broome	TOTALS:	27,563	1,588	352	-	12	-
	Capital District Physicians Health Plan	276	16	-	-	-	-
	Excellus Health Plan	22,126	1,314	-	-	-	-
	Fidelis Care at Home	-	-	-	-	12	-
	NYS Catholic Health Plan	4,600	229	-	-	-	-
	United Healthcare Plan of NY	561	29	-	-	-	-
	Wellcare of New York	-	-	352	-	-	-
Cattaraugus	TOTALS:	9,766	686	-	-	81	-
	Fidelis Care at Home	-	-	-	-	1	-
	HealthNow	4,515	240	-	-	-	-
	NYS Catholic Health Plan	3,277	272	-	-	-	-
	Total Senior Care	-	-	-	-	80	-
Cayuga	TOTALS:	9,261	545	-	-	3	-
	Fidelis Care at Home	-	-	-	-	1	-
	NYS Catholic Health Plan	7,078	383	-	-	-	-
	United Healthcare Plan of NY	2,183	162	-	-	-	-
	VNA Homecare Options	-	-	-	-	2	-
Chautauqua	TOTALS:	22,104	962	-	-	1	-
	Fidelis Care at Home	-	-	-	-	1	-
	HealthNow	4,153	198	-	-	-	-
	NYS Catholic Health Plan	16,865	690	-	-	-	-
	United Healthcare Plan of NY	4	4	-	-	-	-
Chemung	TOTALS:	12,799	466	-	-	-	-
	NYS Catholic Health Plan	10,878	414	-	-	-	-

Section Five: Resources

Chapter 1: New York Comprehensive Environmental Scan

County	Plan Name	Medicaid Managed Care	Family Health Plus	Medicaid Advantage	Medicaid Advantage Plus	Managed Long Term Care	Commercial
Chenango	United Healthcare Plan of NY	1,921	52	-	-	-	-
	TOTALS:	6,564	421	-	-	1	-
	Fidelis Care at Home	-	-	-	-	1	-
	NYS Catholic Health Plan	5,600	384	-	-	-	-
Clinton	United Healthcare Plan of NY	964	37	-	-	-	-
	TOTALS:	9,859	684	-	-	-	-
	NYS Catholic Health Plan	8,947	606	-	-	-	-
	United Healthcare Plan of NY	912	78	-	-	-	-
Columbia	TOTALS:	6,791	489	8	-	29	-
	Capital District Physicians Health Plan	3,708	190	-	-	-	-
	Fidelis	-	-	8	-	-	-
	Fidelis Care at Home	-	-	-	-	5	-
	NYS Catholic Health Plan	3,050	294	-	-	-	-
	VNS Choice	-	-	-	-	24	-
	United Healthcare Plan of NY	33	5	-	-	-	-
Cortland	TOTALS:	6,487	503	-	-	2	-
	Fidelis Care at Home	-	-	-	-	2	-
	NYS Catholic Health Plan	5,004	395	-	-	-	-
	Today's Options	1,483	108	-	-	-	-
Delaware	TOTALS:	4,887	379	-	-	9	-
	Fidelis Care at Home	-	-	-	-	9	-
	NYS Catholic Health Plan	4,887	379	-	-	-	-
Dutchess	TOTALS:	23,504	1,790	77	-	112	-
	Elant	-	-	-	-	77	-
	Fidelis	-	-	25	-	-	-
	Fidelis Care at Home	-	-	-	-	21	-
	Hudson Health Plan	14,347	1,021	-	-	-	-
	NYS Catholic Health Plan	6,560	571	-	-	-	-
	VNS Choice	-	-	-	-	14	-
	Wellcare of New York	2,597	198	52	-	-	-
Erie	TOTALS:	129,954	7,995	1,093	-	850	-
	Centers Plan for Healthy Living	-	-	-	-	63	-
	CHS Buffalo Life	-	-	-	-	168	-
	ElderPlan	-	-	-	-	3	-
	ErieNiagara MLTCP	-	-	-	-	60	-
	Fidelis Care at Home	-	-	-	-	178	-
	HealthNow	24,002	1,432	-	-	-	-
	Independent Health Association	39,004	2,072	-	-	-	-
	NYS Catholic Health Plan	32,524	1,896	-	-	-	-
	Total Aging in Place Program	-	-	-	-	127	-
	United Healthcare Plan of NY	-	-	-	-	3	-
	Univera Community Health	34,424	2,595	-	-	-	-
Essex	TOTALS:	3,477	375	-	-	2	-
	Fidelis Care at Home	-	-	-	-	2	-
	NYS Catholic Health Plan	3,412	361	-	-	-	-
	United Healthcare Plan of NY	65	14	-	-	-	-

Section Five: Resources

Chapter 1: New York Comprehensive Environmental Scan

County	Plan Name	Medicaid Managed Care	Family Health Plus	Medicaid Advantage	Medicaid Advantage Plus	Managed Long Term Care	Commercial
Franklin	TOTALS:	5,103	327	-	-	-	-
	NYS Catholic Health Plan	5,103	327	-	-	-	-
Fulton	TOTALS:	8,247	657	-	-	12	-
	Capital District Physicians Health Plan	1,301	83	-	-	-	-
	Fidelis Care at Home	-	-	-	-	12	-
	NYS Catholic Health Plan	6,924	571	-	-	-	-
	United Healthcare Plan of NY	22	3	-	-	-	-
Genesee	TOTALS:	5,473	494	-	-	-	-
	MVP Health Plan	3,270	254	-	-	-	-
	NYS Catholic Health Plan	2,143	238	-	-	-	-
	United Healthcare Plan of NY	60	2	-	-	-	-
Greene	TOTALS:	5,931	406	7	-	12	-
	Capital District Physicians Health Plan	3,023	159	-	-	-	-
	Fidelis	-	-	7	-	-	-
	NYS Catholic Health Plan	2,908	247	-	-	-	-
	VNS Choice	-	-	-	-	12	-
Hamilton	TOTALS:	394	46	-	-	-	-
	NYS Catholic Health Plan	394	46	-	-	-	-
Herkimer	TOTALS:	8,525	880	10	-	59	-
	Excellus Health Plan	1,547	165	-	-	-	-
	Fidelis	-	-	10	-	-	-
	Fidelis Care at Home	-	-	-	-	11	-
	NYS Catholic Health Plan	6,936	710	-	-	-	-
	Senior Network Health	-	-	-	-	48	-
	United Healthcare Plan of NY	42	5	-	-	-	-
Jefferson	TOTALS:	12,755	755	-	-	-	-
	United Healthcare Plan of NY	12,755	755	-	-	-	-
Lewis	TOTALS:	3,117	136	-	-	-	-
	NYS Catholic Health Plan	2,278	112	-	-	-	-
	United Healthcare Plan of NY	839	24	-	-	-	-
Livingston	TOTALS:	6,299	451	-	-	24	-
	Excellus Health Plan	4,387	336	-	-	-	-
	Fidelis Care at Home	-	-	-	-	24	-
	MVP Health Plan	1,134	56	-	-	-	-
	NYS Catholic Health Plan	778	59	-	-	-	-
Madison	TOTALS:	7,291	753	-	-	21	-
	NYS Catholic Health Plan	5,436	548	-	-	-	-
	United Healthcare Plan of NY	1,855	205	-	-	-	-
	VNA Homecare Options	-	-	-	-	21	-
Monroe	TOTALS:	108,904	6,976	279	-	1,200	-
	Excellus Health Plan	75,829	5,208	-	-	-	-
	ElderPlan	-	-	-	-	453	-
	Fidelis Care at Home	-	-	-	-	170	-
	Independent Living for Seniors	-	-	-	-	560	-
	MVP Health Plan	14,169	509	-	-	-	-

Section Five: Resources

Chapter 1: New York Comprehensive Environmental Scan

County	Plan Name	Medicaid Managed Care	Family Health Plus	Medicaid Advantage	Medicaid Advantage Plus	Managed Long Term Care	Commercial
	NYS Catholic Health Plan	17,056	1,062	-	-	-	-
	United Healthcare Plan of NY	1,850	197	-	-	3	-
	VNS Choice	-	-	-	-	14	-
	Wellcare of New York	-	-	279	-	-	-
Montgomery	TOTALS:	8,861	782	24	4	14	-
	Capital District Physicians Health Plan	3,328	255	-	-	-	-
	Fidelis	-	-	24	-	-	-
	Fidelis Care at Home	-	-	-	-	14	-
	NYS Catholic Health Plan	5,533	527	-	4	-	-
Nassau	TOTALS:	128,254	16,850	315	166	4,418	-
	Aetna Better Health	-	-	-	-	264	-
	Agewell New York	-	-	-	-	363	-
	Affinity Health Plan	16,881	2,163	-	-	-	-
	Amerigroup	11,914	1,738	-	-	-	-
	CCM Select	-	-	-	-	132	-
	Comprehensive Care Management	-	-	-	-	62	-
	ElderPlan	-	-	-	4	130	-
	ElderServe	-	-	-	-	93	-
	Extended MLTC	-	-	-	-	29	-
	Fidelis Care at Home	-	-	-	-	583	-
	Guildnet	-	-	-	72	1,531	-
	HealthFirst PHSP	24,018	3,188	-	15	-	-
	HIP of Greater New York	19,383	1,966	103	75	253	-
	Integra	-	-	-	-	55	-
	Liberty Health Advantage	-	-	51	-	-	-
	Managed Health	-	-	12	-	-	-
	North Shore-LIJ Health Plan	-	-	-	-	315	-
	NYS Catholic Health Plan	27,451	3,516	-	-	-	-
	Senior Health Partners, Inc.	-	-	-	-	201	-
	United Healthcare Plan of NY	28,607	4,279	147	-	-	-
	VNS Choice	-	-	2	-	345	-
	Wellcare of New York	-	-	-	-	62	-
Niagara	TOTALS:	27,366	1,901	239	-	151	-
	Centers Plan for Healthy Living	-	-	-	-	35	-
	Complete Senior Care	-	-	-	-	116	-
	Independent Health Association	10,820	-	-	-	-	-
	NYS Catholic Health Plan	16,035	1,828	-	-	-	-
	United Healthcare Plan of NY	511	73	-	-	-	-
	Wellcare of New York	-	-	239	-	-	-
Oneida	TOTALS:	38,076	2,984	292	-	465	-
	Excellus Health Plan	7,277	620	-	-	-	-
	Fidelis	-	-	57	-	-	-
	Fidelis Care at Home	-	-	-	-	32	-
	NYS Catholic Health Plan	26,604	2,081	-	-	-	-
	Senior Network Health	-	-	-	-	433	-
	United Healthcare Plan of NY	4,195	283	-	-	-	-

Section Five: Resources

Chapter 1: New York Comprehensive Environmental Scan

County	Plan Name	Medicaid Managed Care	Family Health Plus	Medicaid Advantage	Medicaid Advantage Plus	Managed Long Term Care	Commercial
Onondaga	Wellcare of New York	-	-	235	-	-	-
	TOTALS:	62,199	4,221	414	-	803	-
	ElderPlan	-	-	-	-	1	-
	Fidelis	-	-	59	-	-	-
	Fidelis Care at Home	-	-	-	-	45	-
	NYS Catholic Health Plan	23,676	1,937	-	-	-	-
	Pace CNY	-	-	-	-	463	-
	Today's Options	27,370	1,389	-	-	-	-
	United Healthcare Plan of NY	11,153	895	-	-	12	-
	VNA Homecare Options	-	-	-	-	280	-
	VNS Choice	-	-	-	-	2	-
Ontario	Wellcare of New York	-	-	355	-	-	-
	TOTALS:	9,689	865	-	-	1	-
	Excellus Health Plan	8,728	790	-	-	-	-
	Fidelis Care at Home	-	-	-	-	1	-
	MVP Health Plan	641	45	-	-	-	-
	NYS Catholic Health Plan	316	30	-	-	-	-
Orange	United Healthcare Plan of NY	4	-	-	-	-	-
	TOTALS:	54,158	3,321	79	-	930	-
	Affinity Health Plan	15,801	1,118	-	-	-	-
	Elant	-	-	-	-	283	-
	ElderPlan	-	-	-	-	1	-
	Fidelis Care at Home	-	-	-	-	417	-
	Hamaspik Choice	-	-	-	-	90	-
	Hudson Health Plan	14,756	1,041	-	-	-	-
	NYS Catholic Health Plan	21,141	968	-	-	-	-
	Touchstone/Prestige	-	-	43	-	-	-
	United Healthcare Plan of NY	591	59	-	-	-	-
	VNS Choice	-	-	-	-	20	-
Orleans	Wellcare of New York	1,869	135	36	-	119	-
	TOTALS:	5,852	413	-	-	-	-
	Excellus Health Plan	2,243	137	-	-	-	-
	HealthNow	1,200	72	-	-	-	-
	NYS Catholic Health Plan	2,409	204	-	-	-	-
Oswego	TOTALS:	19,716	1,305	51	-	9	-
	Fidelis	-	-	51	-	-	-
	Fidelis Care at Home	-	-	-	-	6	-
	NYS Catholic Health Plan	13,461	879	-	-	-	-
	VNA Homecare Options	-	-	-	-	3	-
	United Healthcare Plan of NY	6,255	426	-	-	-	-
Otsego	TOTALS:	5,807	456	-	-	-	-
	Excellus Health Plan	3,099	190	-	-	-	-
	NYS Catholic Health Plan	2,708	266	-	-	-	-

Section Five: Resources

Chapter 1: New York Comprehensive Environmental Scan

County	Plan Name	Medicaid Managed Care	Family Health Plus	Medicaid Advantage	Medicaid Advantage Plus	Managed Long Term Care	Commercial
Putnam	TOTALS:	3,589	325	-	-	42	-
	Amerigroup	156	-	-	-	-	-
	Archcare Community Life	-	-	-	-	30	-
	Fidelis Care at Home	-	-	-	-	12	-
	NYS Catholic Health Plan	3,433	325	-	-	-	-
Rensselaer	TOTALS:	18,832	1,163	83	26	72	-
	Capital District Physicians Health Plan	13,529	701	-	-	-	-
	ElderPlan	-	-	-	-	6	-
	Fidelis	-	-	22	-	-	-
	Fidelis Care at Home	-	-	-	-	14	-
	NYS Catholic Health Plan	4,459	395	-	26	-	-
	United Healthcare Plan of NY	53	7	-	-	-	-
	VNS Choice	-	-	-	-	52	-
	Wellcare of New York	791	60	61	-	-	-
Rockland	TOTALS:	60,568	4,054	47	-	1,156	-
	Affinity Health Plan	5,080	424	-	-	-	-
	CCM Select	-	-	-	-	231	-
	Centers Plan for Healthy Living	-	-	-	-	23	-
	Elant	-	-	-	-	251	-
	ElderPlan	-	-	-	-	13	-
	Fidelis Care at Home	-	-	-	-	392	-
	Hamaspik Choice	-	-	-	-	96	-
	Hudson Health Plan	10,726	848	-	-	-	-
	NYS Catholic Health Plan	41,969	2,614	-	-	-	-
	United Healthcare Plan of NY	716	96	-	-	1	-
	VNS Choice	-	-	-	-	16	-
	Wellcare of New York	2,077	72	47	-	133	-
St Lawrence	TOTALS:	14,161	717	-	-	-	-
	NYS Catholic Health Plan	10,299	520	-	-	-	-
	United Healthcare Plan of NY	3,862	197	-	-	-	-
Saratoga	TOTALS:	14,840	1,286	48	-	14	-
	Capital District Physicians Health Plan	9,784	694	-	-	-	-
	NYS Catholic Health Plan	5,056	592	-	-	-	-
	VNS Choice	-	-	-	-	14	-
	Wellcare of New York	-	-	48	-	-	-
Schenectady	TOTALS:	22,843	1,613	164	25	167	-
	Capital District Physicians Health Plan	11,702	626	-	-	-	-
	Eddy Senior Care	-	-	-	-	137	-
	ElderPlan	-	-	-	-	2	-
	Fidelis	-	-	70	-	-	-
	Fidelis Care at Home	-	-	-	-	28	-
	NYS Catholic Health Plan	11,141	987	-	25	-	-
	Wellcare of New York	-	-	94	-	-	-
Schoharie	TOTALS:	3,538	362	-	-	-	-
	Capital District Physicians Health Plan	2,138	219	-	-	-	-

Section Five: Resources

Chapter 1: New York Comprehensive Environmental Scan

County	Plan Name	Medicaid Managed Care	Family Health Plus	Medicaid Advantage	Medicaid Advantage Plus	Managed Long Term Care	Commercial
	NYS Catholic Health Plan	1,400	143	-	-	-	-
Schuyler	TOTALS:	2,100	178	-	-	-	-
	NYS Catholic Health Plan	2,100	178	-	-	-	-
Seneca	TOTALS:	3,693	300	-	-	-	-
	Excellus Health Plan	3,653	300	-	-	-	-
	NYS Catholic Health Plan	3	-	-	-	-	-
	United Healthcare Plan of NY	37	-	-	-	-	-
Steuben	TOTALS:	11,784	896	-	-	1	-
	Fidelis Care at Home	-	-	-	-	1	-
	NYS Catholic Health Plan	11,784	896	-	-	-	-
Suffolk	TOTALS:	143,681	15,138	58	109	2,872	-
	Aetna Better Health	-	-	-	-	265	-
	Agewell New York	-	-	-	-	148	-
	Affinity Health Plan	20,607	2,295	-	-	-	-
	CCM Select	-	-	-	-	170	-
	Comprehensive Care Management	-	-	-	-	85	-
	ElderPlan	-	-	-	-	41	-
	ElderServe	-	-	-	-	124	-
	Extended MLTC	-	-	-	-	3	-
	Fidelis Care at Home	-	-	-	-	397	-
	Guildnet	-	-	-	83	1,394	-
	HealthFirst PHSP	42,331	3,544	-	-	-	-
	HIP of Greater New York	18,634	1,862	58	26	66	-
	Integra	-	-	-	-	24	-
	North Shore-LIJ Health Plan	-	-	-	-	35	-
	NYS Catholic Health Plan	28,619	3,505	-	-	-	-
	United Healthcare Plan of NY	33,490	3,932	-	-	-	-
	VNS Choice	-	-	-	-	105	-
	Wellcare of New York	-	-	-	-	15	-
Sullivan	TOTALS:	12,596	1,012	-	-	108	-
	Fidelis Care at Home	-	-	-	-	18	-
	Hamaspik Choice	-	-	-	-	89	-
	Hudson Health Plan	9,279	735	-	-	-	-
	NYS Catholic Health Plan	3,317	277	-	-	-	-
	VNS Choice	-	-	-	-	1	-
Tioga	TOTALS:	5,309	438	-	-	4	-
	Capital District Physicians Health Plan	1,628	169	-	-	-	-
	Fidelis Care at Home	-	-	-	-	4	-
	NYS Catholic Health Plan	3,409	239	-	-	-	-
	United Healthcare Plan of NY	272	30	-	-	-	-
Tompkins	TOTALS:	7,761	416	-	-	2	-
	Fidelis Care at Home	-	-	-	-	2	-
	NYS Catholic Health Plan	2,559	153	-	-	-	-
	Today's Options	5,202	263	-	-	-	-
Ulster	TOTALS:	20,379	1,819	54	-	150	-
	Fidelis	-	-	17	-	-	-
	Fidelis Care at Home	-	-	-	-	82	-

Section Five: Resources

Chapter 1: New York Comprehensive Environmental Scan

County	Plan Name	Medicaid Managed Care	Family Health Plus	Medicaid Advantage	Medicaid Advantage Plus	Managed Long Term Care	Commercial
	Hamaspik Choice	-	-	-	-	26	-
	Hudson Health Plan	11,034	1,097	-	-	-	-
	NYS Catholic Health Plan	6,241	484	-	-	-	-
	United Healthcare Plan of NY	350	29	-	-	-	-
	VNS Choice	-	-	-	-	1	-
	Wellcare of New York	2,754	209	37	-	41	-
Warren	TOTALS:	5,932	464	-	-	1	-
	Fidelis Care at Home	-	-	-	-	1	-
	NYS Catholic Health Plan	5,258	432	-	-	-	-
	United Healthcare Plan of NY	674	32	-	-	-	-
Washington	TOTALS:	6,973	627	-	-	4	-
	Capital District Physicians Health Plan	2,755	181				
	Fidelis Care at Home					4	
	NYS Catholic Health Plan	4,218	446				
Wayne	TOTALS:	10,015	561	14	-	1	-
	Excellus Health Plan	8,613	499	-	-	-	-
	Fidelis Care at Home	-	-	-	-	1	-
	NYS Catholic Health Plan	1,387	62	-	-	-	-
	United Healthcare Plan of NY	15	-	-	-	-	-
	Wellcare of New York	-	-	14	-	-	-
Westchester	TOTALS:	100,343	8,982	271	5	2,915	-
	Affinity Health Plan	16,054	1,344	-	-	-	-
	Agewell New York	-	-	-	-	293	-
	Alphacare	-	-	-	-	9	-
	Archcare Community Life	-	-	-	-	430	-
	CCM Select	-	-	-	-	369	-
	Comprehensive Care Management	-	-	-	-	223	-
	ElderPlan	-	-	-	-	329	-
	ElderServe	-	-	-	-	143	-
	Fidelis Care at Home	-	-	-	-	252	-
	Guildnet	-	-	-	-	209	-
	HHH Choices	-	-	-	-	89	-
	HIP of Greater New York	8,476	614	12	5	41	-
	Hudson Health Plan	52,337	4,540	-	-	-	-
	Integra	-	-	-	-	33	-

Section Five: Resources

Chapter 1: New York Comprehensive Environmental Scan

County	Plan Name	Medicaid Managed Care	Family Health Plus	Medicaid Advantage	Medicaid Advantage Plus	Managed Long Term Care	Commercial
	Managed Health	-	-	3	-	-	-
	Montefiore HMO	-	-	-	-	49	-
	NYS Catholic Health Plan	21,422	2,178	-	-	-	-
	Senior Health Partners, Inc.	-	-	-	-	162	-
	Touchstone/Prestige	-	-	255	-	-	-
	United Healthcare Plan of NY	2,054	306	-	-	-	-
	VNS Choice	-	-	1	-	254	-
	Wellcare of New York	-	-	-	-	30	-
Wyoming	TOTALS:	2,957	327	-	-	-	-
	HealthNow	1,979	230	-	-	-	-
	NYS Catholic Health Plan	978	97	-	-	-	-
Yates	TOTALS:	2,542	230	-	-	-	-
	Excellus Health Plan	2,533	230	-	-	-	-
	NYS Catholic Health Plan	9	-	-	-	-	-
Upstate Total		1,316,766	105,540	4,217	386	17,091	-
NYC	Aetna Better Health	-	-	-	-	2,099	
	Agewell New York	-	-	-	-	2,430	
	Alphacare	-	-	-	-	545	
	Archcare Community Life	-	-	-	-	1,407	
	Archcare Senior Life	-	-	-	-	339	
	Affinity Health Plan	139,586	9,505	375	-	-	-
	Amerigroup	317,491	26,095	-	6	2,798	-
	Amida Care SN	6,035	-	-	-	-	-
	CCM Select	-	-	-	-	8,468	-
	Centers Plan for Healthy Living	-	-	-	-	1,669	-
	Comprehensive Care Management	-	-	-	-	3,435	-
	ElderPlan	-	-	1	798	9,620	-
	ElderServe	-	-	-	-	10,009	-
	Extended MLTC	-	-	-	-	228	-
	Fidelis	-	-	1,465	-	-	-
	Fidelis Care at Home	-	-	-	-	5,767	-
	Guildnet	-	-	-	540	11,229	-
	HealthFirst PHSP	612,325	37,528	-	2,836		-

Section Five: Resources

Chapter 1: New York Comprehensive Environmental Scan

County	Plan Name	Medicaid Managed Care	Family Health Plus	Medicaid Advantage	Medicaid Advantage Plus	Managed Long Term Care	Commercial
	HHH Choices	-	-	-	-	2,190	-
	HIP of Greater New York	139,456	10,076	845	523	978	-
	Independence Care Systems	-	-	-	-	5,081	-
	Integra	-	-	-	-	1,151	-
	Liberty Health Advantage	-	-	323	-	-	-
	Managed Health	-	-	187	-	-	-
	MetroPlus Health Plan SN	5,217	-	-	-	-	-
	MetroPlus Health Plan	340,053	20,284	513	-	577	-
	Montefiore HMO	-	-	-	-	290	-
	North Shore-LIJ Health Plan	-	-	-	-	381	-
	NYS Catholic Health Plan	297,450	26,564	-	86	-	-
	Senior Health Partners, Inc.	-	-	-	-	10,879	-
	Senior Whole Health	-	-	-	29	916	-
	Touchstone/Prestige	-	-	1,617	-	-	-
	United Healthcare Plan of NY	204,405	18,281	1,000	-	746	-
	Village Care	-	-	-	-	2,944	-
	VNS Choice SN	4,787	-	410	223	16,446	-
	Wellcare of New York	57,965	4,612	-	-	5,712	-
	NYC Total	2,124,770	152,945	6,736	5,041	108,334	-
	UPSTATE TOTALS:	1,316,766	105,540	4,217	386	17,091	-
	NEW YORK CITY TOTALS:	2,124,770	152,945	6,736	5,041	108,334	-
	GRAND TOTALS:	3,441,536	258,485	10,953	5,427	125,425	-
NYC Boroughs	Bronx	503,231	25,201				
	Brooklyn	757,201	54,053				
	Manhattan	249,355	13,192				
	Queens	541,998	54,713				
	Staten Island	72,985	5,786				
	Borough Total	2,124,770	152,945				

Chapter 2: IPAs

MEMORANDUM

TO: Toni Lasicki, Executive Director

FROM: Kurt Bratten, Esq.
Caitlin Monjeau, Esq.
Carla R. Williams MPA, Director of Healthcare Consulting Group

RE: Independent Practice Associations in New York

Date: December 2, 2014

I. WHAT IS AN IPA?

The term, Independent Practice Association, or IPA, is used to refer to several very different types of entities. Some of these entities are not regulated in New York and are not relevant to this Memorandum. For instance, the term IPA is sometimes used to refer to physician-owned alliances that provide services to third parties. In this type of IPA, physicians organize their alliance as an independent legal entity in which the physicians share financial risk but not overhead. This type of IPA may contract with a health maintenance organization, or HMO, to service enrollees but does not need to do so and can provide services in a non-HMO context. An IPA can also be an association of independent providers, or it can simply be a corporate entity involving no providers but that bears the name, Independent Practice Association or IPA. Not all IPAs are regulated by state law, but those IPAs that contract with Managed Care Organizations, or MCOs, are regulated in New York. Significantly, New York does not preclude entities from operating in an unregulated manner that use “Independent Practice Association” or “IPA” in their names.

The type of IPA that is regulated in New York and that is the subject of this Memorandum is one that contracts with providers to furnish medical services, and that provides services to one or more MCOs, typically on a capitated basis. In New York, the IPA model can be used to help providers contract with MCOs just as it can be used by MCOs to assist with their operations. Even among this type of regulated IPA, there are several different kinds of IPAs with different characteristics, corporate structures and objectives.

In New York, the precise level of regulation on an IPA depends on the nature of its contractual arrangements with the MCOs.² IPAs can serve several distinct roles within the

² The regulations applicable to IPAs are set forth in Part 98 of Title 10 of the New York State regulations.

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managed care regulatory scheme. The primary role served by regulated IPAs is as an intermediary between an MCO³ and providers of medical or medically related services to make the services of such providers available to the enrollees of the MCO and/or to injured workers participating in a workers' compensation preferred provider arrangement. An IPA can also be an intermediary by contracting with a second IPA in order to make the second IPA's contracted providers' services available to enrollees of an MCO. IPAs may serve another role by entering into management contracts with MCOs to perform delegable management functions for an MCO. The regulatory scheme New York has created does not address IPAs that do not enter into one of these contractual relationships.

In New York, IPAs must be created under state law and can take several different forms. IPAs can be corporations, limited liability corporations or professional limited liability corporations.⁴ An IPA cannot be an Article 28 organization, nor an Article 36 (home care services agency), 40 (hospice), 44 (HMO), or 47 (shared health facility) organization, as defined under the Public Health Law. These limitations regarding a regulated IPA's corporate form are rigid.

Like any other corporate entity, IPAs must decide numerous important issues regarding corporate composition, purpose and governance at the time of formation. For instance, IPAs must choose whether to be taxable or tax exempt entities, and select a name, business purpose, and governance and decision-making structures. Most significantly, an IPA must decide its purpose at an early stage because it must be laid out in the certificate of incorporation or articles of organization and will drive most of its formation and governance decisions. An IPA's purpose is dependent on the role it intends to fill vis-à-vis the Managed Care Organizations and it is critical that an IPA's corporate documents authorize the market strategy that it intends to pursue as this is a regulatory requirement. The legal scheme imposes additional corporate requirements on IPAs which are discussed in more detail below. For these reasons, the formation and structuring of an IPA is critical to its success.

II. TYPES OF IPAS

Generally speaking, there are three types of regulated IPAs operating in the managed care environment: (1) independent; (2) captive; and (3) MCO partnership IPAs. All three IPA models can and are being utilized, however, most IPAs do not advertise which model they have followed.

Independent IPAs offer the greatest amount of freedom to providers and permit member providers to substantially increase their leverage and negotiating power by teaming up. Independent IPAs allow providers, particularly smaller or less geographically significant providers, to form a group that MCOs must deal with. This increased leverage often stems from the regional or industry-specific nature of an independent IPA, so serious consideration must be

³ IPAs can serve the same intermediary role in between workers' compensation preferred provider organizations (PPOs) and providers of medical or medically related services.

⁴ See 10 N.Y.C.R.R. § 98-1.2(w).

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given to the scope and membership requirements of an independent IPA. This type of IPA can be integrated to operate like a provider network but most are far less assimilated. At a minimum, independent IPAs are required to offer some “clinical and financial integration” among provider members. For example, an independent IPA cannot be formed purely to negotiate rates. It must also share some financial risk or agree to some performance-based incentives through its MCO contract to qualify as an IPA.

Captive IPAs are usually owned, operated, and controlled by an MCO so that maximum power is exerted by the MCO over the network and its participants. This typically eliminates the need to negotiate contracts and fully aligns the IPA with the MCO and its objectives. Provider contracts in captive IPA networks are normally offered on a “take it or leave it” basis where no negotiation is offered and their execution is a merely formality. The captive model is frequently used with hospitals or large health systems where most of the providers are employed by one large, lead provider. From the provider perspective, this can be dangerous because many participating provider agreements leave decision-making to the MCO on a wide range of organizational activities.

Partnership IPAs involve a 50/50 shared ownership and control structure between the MCO and the IPA provider members. This model offers features of both the independent and captive IPA models. Provided there is agreement between the MCO and IPA members, this model preserves a level of provider independence while strongly aligning the IPA with an MCO. The partnership IPA model is also the most difficult to manage because the goals of MCOs and providers are often very different and/or grow further apart over time. There is nothing inherent in the partnership model that aids participants in resolving the differing objectives that arise between an MCO concerned with profitability and care-centric providers. As a result, this model is extremely difficult to implement effectively.

It is important to keep in mind that MCOs are allowed to contract with parent, sister or subsidiary entities, or any other entity licensed or certified in another state, in order to make services available to enrollees or to provide enrollees with discounted rates while traveling out-of-state. A MCO-IPA relationship between entities that are affiliated or under common control allows an MCO to exert a high degree of control over the IPA and its provider network. Accordingly, captive and partnership IPAs are perfectly legal and these models are being used in practice today.

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III. WHAT CAN AN IPA DO?

An IPA can perform essentially four different functions and roles vis-à-vis MCOs. Since an IPA must define its purpose and powers in its corporate documents at the time it is formed, an IPA must develop its strategy early. The powers available to an IPA⁵ are defined, and limited, by law, and the applicable regulatory obligations depend upon the function an IPA serves.

The IPA as an Intermediary Entity: Direct Contracting

IPAs may contract directly with providers of medical or medically-related services, in addition to MCOs⁶ and/or workers' compensation PPOs. Through this contractual relationship with an MCO or PPO, the IPA is supposed to "make the services of . . . providers available to the enrollees" of the MCO or PPO plan.⁷ In such arrangements, the IPA is deemed an "intermediary entity" because the contracts that these IPAs enter into with the MCO and/or PPO require the IPA to share risk with the MCO or PPO through a capitation arrangement for the delivery of services to the plan subscribers. New York defines this type of arrangement as a "financial risk transfer agreement"⁸ and imposes more stringent regulatory requirements on participants. For instance, an HMO cannot agree to transfer risk to an IPA through a capitation arrangement unless the IPA first demonstrates that it is financially secure.⁹ More specifically, an IPA planning to share risk must demonstrate to the Commissioner of Health or, in some circumstances, the Superintendent of Insurance, that it is "financially responsible and capable of assuming such risk and has satisfactory insurance, stop-loss, reserves or other arrangements so that it may be expected to satisfy its obligations to MCOs, providers and enrollees[.]"¹⁰

⁵ See 10 N.Y.C.R.R. § 98-1.5(b)(6)(vii)(e)(I).

⁶ Managed Care Organizations are defined to include health maintenance organizations (HMOs), special purpose health maintenance organizations, also known as a prepaid health services plans (PHSPs), comprehensive HIV special needs plan (HIV SNPs), primary care partial capitation providers (PCPCPs), and managed long term care plans (MLTCPs). See 10 N.Y.C.R.R. § 98-1.2(w).

⁷ See 10 N.Y.C.R.R. § 98-1.2(w).

⁸ The law defines "financial risk transfer" as "the contractual assumption of liability by the health care provider by means of a capitation arrangement for the delivery of specified health care services to subscribers of the insurer." 11 N.Y.C.R.R. § 101.3(c). A "capitation arrangement," in turn, is defined as "contractually based prepayments . . . made to a health care provider, on a per member per month or a percentage of premium basis, in exchange for one or more covered health care services to be rendered, referred or otherwise arranged by such provider and by its participating providers[.]" 11 N.Y.C.R.R. § 101.3(a).

⁹ See 11 N.Y.C.R.R. § 101.5.

¹⁰ See 10 N.Y.C.R.R. § 98-1.5(b)(6)(vii)(e)(I).

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In these financial risk transfer agreements, IPAs share risk¹¹ in two possible ways: the IPA and the HMO may share financial risk under a contract, or the HMO may have a “financial incentive arrangement” with the IPA. Generally, a financial incentive arrangement involves the IPA being subject to risk or reward based on performance.

The IPA as an Intermediary Entity: IPA to IPA Contracting

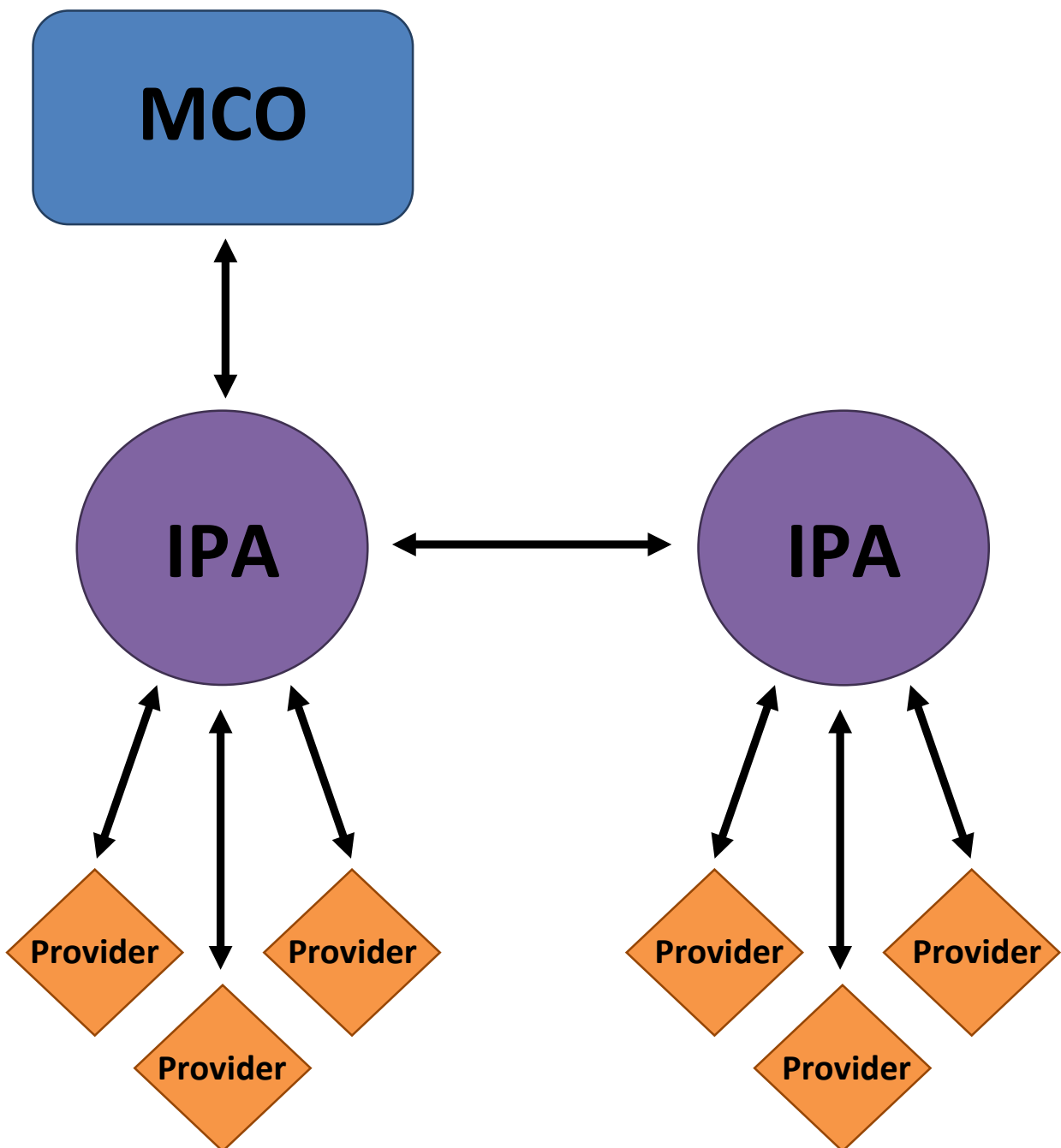
There is another contractual arrangement available to IPAs that involves risk sharing but that does not include a direct contractual relationship with an MCO. IPAs are permitted¹² to contract with another IPA to make service providers available to an MCO. In this scenario, an IPA that has a contract with an MCO or workers’ compensation PPO to arrange for the delivery of services can arrange for those services not by contracting directly with providers itself, but by contracting with another IPA, or IPAs, for the delivery of services to the MCO or PPO. See Figure 1, below.

¹¹ See Public Health Law § 4403(1)(c).

¹² See 10 N.Y.C.R.R. § 98-1.5(b)(6)(vii)(e)(4).

FIGURE 1

DIFFERENT IPA RISK SHARING ARRANGEMENTS AVAILABLE



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To illustrate this point further, an IPA can contract with an MCO or PPO for the delivery of services while directly contracting with providers to accomplish this goal. In addition, that same IPA could also contract with another IPA, or IPAs, which have contracts with other service providers. In this way, the contracting IPAs can expand the network of providers that they make available to their contracted MCOs and/or PPOs.

Like an IPA contracting directly with MCOs and providers, which serves the traditional intermediary function, IPAs that contract with other IPAs for the purpose of making service providers available to MCOs or PPOs are also sharing risk with the MCOs and PPOs as intermediaries. Thus, the requirements and risks related to “financial risk transfer agreements” (as described in Section III.A) apply equally to IPAs that contract with other IPAs for the purpose of making service providers available to MCOs and PPOs.

Management Contracts with MCOs

IPAs are allowed to perform certain designated management functions¹³ for MCOs, provided that the arrangement is set forth in a management contract that is approved by the Commissioner of Health.¹⁴ While an MCO cannot delegate certain functions, such as authority and control over an IPA’s contracted for management services, the following functions may be delegated to an IPA:

1. Maintenance of books and records.¹⁵
2. Disposing of assets and incurring liabilities associated with the day-to-day operations of an MCO.¹⁶
3. Implementing policies regarding the delivery of health care services.¹⁷
4. Paying claims.¹⁸
5. Implementing MCO budgets and providing for annual audits.¹⁹
6. Quality assurance and improvement activities, subject to significant restrictions.²⁰ If the IPA has a risk-sharing arrangement with the MCO, the MCO may delegate to the IPA either quality assurance and improvement or utilization review, but not both. The MCO must either prescribe or approve of the quality assurance and quality improvement standards. If the MCO approves of the standards, those standards must be “substantially equivalent” to

¹³ See 10 N.Y.C.R.R. § 98-1.5(b)(6)(vii)(e)(2).

¹⁴ See 10 N.Y.C.R.R. § 98-1.11(j).

¹⁵ See 10 N.Y.C.R.R. § 98-1.11(j)(1).

¹⁶ See 10 N.Y.C.R.R. § 98-1.11(j)(2).

¹⁷ See 10 N.Y.C.R.R. § 98-1.11(j)(3).

¹⁸ See 10 N.Y.C.R.R. § 98-1.11(j)(4).

¹⁹ See 10 N.Y.C.R.R. § 98-1.11(j)(5).

²⁰ See 10 N.Y.C.R.R. § 98-1.11(j)(6).

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the MCO's standards and other contractors who perform this function, and must be approved by the Commissioner of Health.

7. Utilization review activities, subject to restrictions similar to those described above in Section III.C.6.²¹ If the IPA has a risk-sharing arrangement with an MCO, the IPA may not conduct both utilization review and quality improvement activities. The MCO must either prescribe or approve of the clinical review standards in question, and the MCO cannot approve of clinical review standards unless those standards are "substantially equivalent" to the MCO's standards and other management contractors. These standards must be approved by the Commissioner of Health.
8. Special investigations unit functions.²²
9. While not technically a delegation of an MCO's management function, IPAs can also "assist in the implementation of the MCO's quality assurance activities and functions."²³ The difference between "assistance in the implementation" of these activities and the delegable function described above in Section III.C.6 is that the IPA cannot have decision making authority and responsibility for implementation. If the IPA has such "decision making authority and responsibility for the implemented functions," then it is considered a delegation and subject to the limitations described in Section III.C.6.

There are additional limitations on IPAs that agree to perform management functions for MCOs. Not only must these contractual arrangements be approved by the Department of Health, but the MCO delegating management functions to the IPA must state, in writing, that the standards the IPA will use in performing these functions are "substantially similar" to those the MCO would apply itself.²⁴ Significantly, IPAs performing these management functions must follow all legal requirements applicable to MCOs relative to the management function(s) being performed,²⁵ including potentially registering as a utilization review agent and following the required timeframes for the function in question.

For IPAs performing management services for an MCO, the law allows access to enrollee medical records inasmuch as it is necessary to perform the functions under a management contract with an MCO.²⁶ Such access to protected health information subjects the IPA to applicable state and federal privacy requirements.

The law does not preclude an IPA from having a management services contract with an MCO, while also having a risk sharing agreement with an MCO or PPO for the delivery of medical services to enrollees. In fact, this type of multifaceted relationship between MCOs and IPAs is common. See [Figure 2](#), below.

²¹ See 10 N.Y.C.R.R. § 98-1.11(j)(7).

²² See 10 N.Y.C.R.R. § 98-1.11(j)(8); 10 N.Y.C.R.R. § 98-1.21(b)(1).

²³ See 10 N.Y.C.R.R. § 98-1.11(j)(6).

²⁴ See 10 N.Y.C.R.R. § 98-1.5(b)(6)(vii)(e)(2).

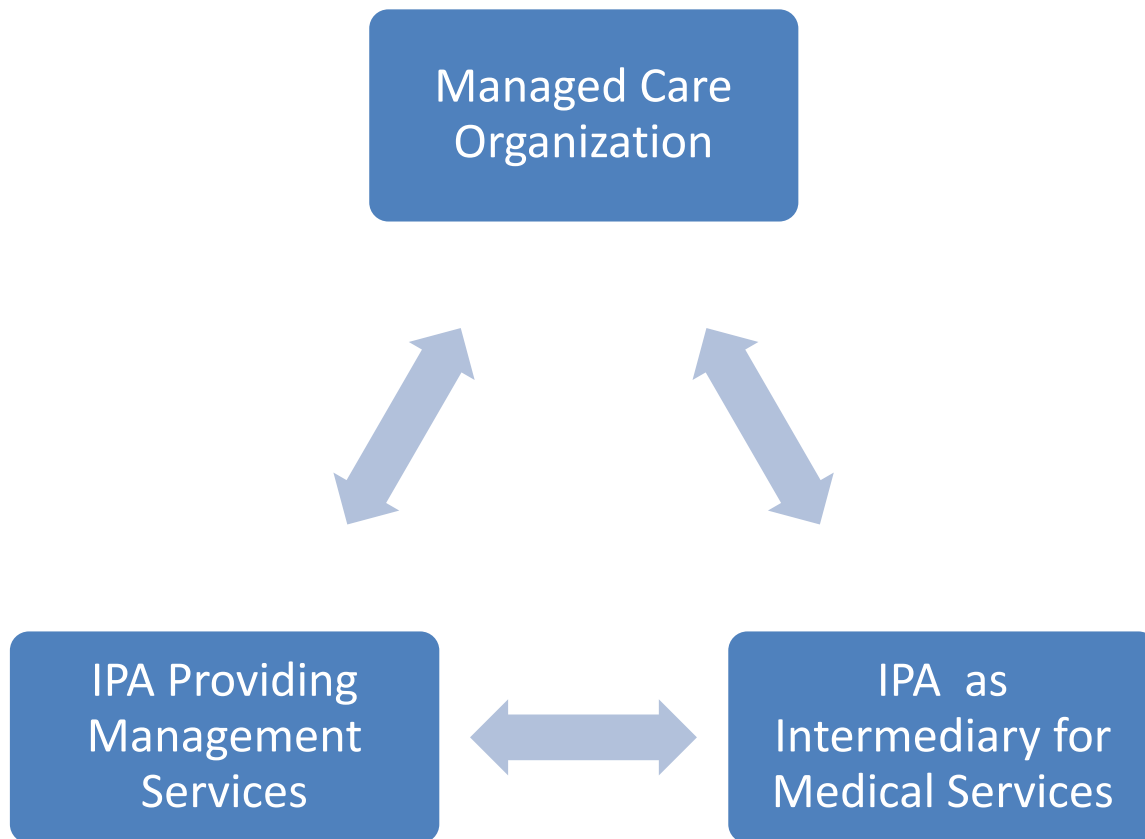
²⁵ See 10 N.Y.C.R.R. § 98-1.5(b)(6)(vii)(e)(2).

²⁶ See 10 N.Y.C.R.R. § 98-1.5(b)(6)(vii)(e)(5).

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FIGURE 2

**IPA FUNCTIONING AS A MANAGEMENT SERVICE CONTRACTOR
AND A RISK SHARING IPA**



IPAs Can Delegate Technical and Administrative Services

IPAs have the right to delegate by contract certain technical or administrative services to third parties.²⁷ While this option does not limit or seemingly affect the other roles that an IPA may serve, and as described above, it is significant in deciding how an IPA will function and partner with other entities. The delegation of services by an IPA allows for greater specialization by the IPA or greater integration with another entity. There are, of course, limitations to what functions an IPA can delegate. For instance, IPAs cannot delegate their governing authority or legal

²⁷ See 10 N.Y.C.R.R. § 98-1.5(b)(6)(vii)(e)(3).

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obligations, nor can they delegate any responsibilities acquired under a management service agreement with an MCO unless the Commissioner of Health and the MCO approve of such a delegation.²⁸

This is similar to the right that MCOs have to delegate non-management functions that are administrative and technical in nature. In practice, MCOs often delegate such administrative and technical functions to IPAs through the contracts they have with the IPA to provide medical services to enrollees.

IV. OBTAINING STATE APPROVAL

The law imposes various regulatory requirements on MCOs, IPAs and their contractual arrangements. In particular, the State has numerous preconditions before it will approve risk-sharing arrangements between an MCO and an IPA. These requirements are discussed in detail below.

A. Requirements Specific to Risk Sharing Arrangements

An MCO must secure approval from the State before it enters into a risk-sharing arrangement with an IPA. This means that the Commissioner of Health or Superintendent of Insurance must approve of the arrangement, in accord with guidelines issued by either authority, before the MCO and IPA can begin operating under a risk sharing arrangement.²⁹ MCOs are required to provide the following information to the Commissioner of Health to secure State approval:

1. A list of the owners, officers, directors, and LLC managers and members of the IPA.³⁰
2. The complete text of the proposed contract between the MCO and IPA, including all attachments. The contract must include agreement by the parties to the following terms:
 - a. To amend or terminate the agreement at the Commissioner of Health's direction.
 - b. The IPA must submit quarterly and annual financial statements to the MCO.
 - c. The MCO must notify the Commissioner of Health of any "substantial change" in the IPA's financial condition.
 - d. All provider contracts under the risk sharing arrangement must include a clause stating that "the provider shall not, in the event of default by the IPA, demand payment from the MCO for any covered services rendered to the MCO's enrollees

²⁸ See 10 N.Y.C.R.R. § 98-1.5(b)(6)(vii)(e)(3).

²⁹ See 10 N.Y.C.R.R. § 98-1.18(e).

³⁰ See 10 N.Y.C.R.R. § 98-1.18(e)(1).

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for which payment was made by the MCO to the IPA pursuant to the financial risk sharing agreement.”³¹

3. If the MCO delegates a management function to the IPA, their contract must mandate compliance with the applicable MCO legal requirements relating to the management function(s) (Subpart 98-1 of Part 98 of Title 10 of the N.Y.C.R.R.).³²
4. The provision of such information concerning the financial condition of the IPA and any other providers participating in the risk-sharing arrangement with the MCO as the Commissioner of Health requires.³³
5. A showing by the MCO and the IPA that the proposed arrangement would not involve improper incentives to providers and will not result in a deterioration in access or the quality of care provided to the MCO’s enrollees.³⁴

An important requirement in this approval process is that contracts between an MCO and an IPA may not be implemented unless all related contracts between the IPA and its providers meet the same requirements. Contracts must be between the MCO and the provider, or the MCO and an IPA. The State will not approve any arrangement where the service providers’ contractual obligations do not lead directly to the MCO, whether through an IPA or not. See [Figure 1](#). Provider contracts with the MCO’s parent or subsidiary corporation, or between a provider and an MCO’s management contractor are insufficient and will not be approved.

The Department of Health has a number of particular requirements and prohibitions relevant to contracts between an MCO and an IPA or between an IPA and an IPA. The Department mandates that these provisions be included in the IPA’s contracts with providers as well. Through guidance³⁵, the Department of Health has provided a litany of contracting principles and specific requirements regarding these IPA contracts, many of which are included in the Department’s Standard Clauses Appendix. Some notable requirements are described below:

1. Contracts between MCOs and IPAs should provide for automatic assignment of the IPA’s provider contracts to the MCO in the event of termination of the MCO-IPA contract, and the IPA’s contracts with providers should contain the same provision. Alternatively, the MCO-IPA contract and the IPA provider contracts shall provide that in the event of termination of the MCO/IPA contract, the provider agrees to continue to provide care to the MCO’s enrollees pursuant to the terms of the MCO/IPA provider agreement for 180 days following the effective date of termination, or until such time as the MCO makes

³¹ See 10 N.Y.C.R.R. § 98-1.18(e)(2).

³² See 10 N.Y.C.R.R. § 98-1.18(e)(3).

³³ See 10 N.Y.C.R.R. § 98-1.18(e)(4).

³⁴ See 10 N.Y.C.R.R. § 98-1.18(e)(5).

³⁵ See http://www.health.ny.gov/health_care/managed_care/hmoipa/guidelines.htm.

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other arrangements, whichever first occurs. Such provisions shall expressly survive termination of the MCO-IPA contract.

2. The MCO-IPA contract must include clear language regarding the reimbursement of providers, including fees for each service or risk arrangement. Additionally, the contract must prescribe:
 - a. the method by which payments to a provider are calculated, including any prospective or retrospective adjustments thereto;
 - b. the time periods within which such calculations will be completed, the dates upon which any such payments and adjustments shall be determined to be due, and the dates upon which any such payments and adjustments will be made;
 - c. the records or information which the MCO will rely upon to calculate payments and adjustments; and
 - d. applicable dispute resolution procedures.
3. A contract between an MCO and an IPA whereby the IPA makes the services of contracted providers available to the MCO's enrollees cannot address any utilization review activities to be conducted by the IPA. An IPA may only perform utilization review activities for an MCO if: (a) the MCO has delegated this function to the IPA in a separate management contract approved by Department of Health; and (b) the IPA has registered as a utilization review agent in accordance with the law.
4. Provider contracts must require that the provider comply with all rules, policies and procedures of the MCO that were established to meet general or specific legal obligations on the MCO, and such further rules and policies concerning the following issues:
 - a. quality improvement/management;
 - b. utilization management, including but not limited to precertification procedures, referral process or protocols, and reporting of clinical encounter data;
 - c. member grievances; and
 - d. provider credentialing.
5. The guidance indicates that these restrictions are not necessarily illegal, but that the following types of restrictions are "not viewed favorably" by the Department because they tend to limit access to services:
 - a. "Most Favored Nation" clauses that allow a plan to unilaterally reduce a negotiated rate to a provider where the provider negotiates a more favorable rate with a competing plan; and
 - b. contractual requirements of "exclusivity" and "exclusion," whereby providers are obligated to avoid other MCOs or IPAs.
6. An MCO or IPA may not transfer liability for its own acts or omissions to a provider, by indemnification or otherwise.

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The approval process for such risk sharing arrangements between MCOs and IPAs is a rigid one that is the primary responsibility of the MCO. More information regarding this process and the Department of Health's requirements is available in the guidance document posted on its website: http://www.health.ny.gov/health_care/managed_care/hmoipa/guidelines.htm.

B. The MCO is Responsible for the IPA

New York law provides that an MCO that contracts with an IPA is responsible for that contract and all downstream contracts that the IPA has with other IPAs and providers of medical or medically related services.³⁶ The MCO is also responsible for the care provided under those agreements "to the same extent as it is responsible for arrangements with all other types of health care providers."³⁷ The MCO's responsibility including being subject to fines for not only its own violations but also for violations of law by its contracted IPAs and all downstream IPAs and providers that the MCO's IPAs contract with.³⁸ This is the primary reason why MCOs are given a high degree of power and authority over the IPAs with which they contract.

By contracting with an MCO, an IPA subjects itself to additional legal requirements, including certain shared legal responsibilities, under law. More specifically, IPAs contracting with MCOs means that aspects of Article 44 of the Public Health Law now apply to such IPAs.³⁹ Article 44 applies to Managed Care Organizations and sets forth legal obligations such as the Prompt Pay Law, which have traditionally been applicable only to insurance companies like HMOs and MLTCPs. These additional requirements are imposed on IPAs by law, including the mandate contract provisions discussed below in Section IV and the requirement that all IPAs contracting with MCOs must account for the funds the IPA receives from the MCO, including all service fees and disbursements of those funds.⁴⁰

While IPAs clearly share some legal responsibility with the MCOs they contract with, there is a limit to an IPA's legal liability. To date, this shared legal responsibility has not been extended to matters such as the payment of claims, although this issue is increasingly being disputed and subject to litigation and administrative rulings. This issue becomes murkier the more intertwined the relationship between the MCO and IPA. At present, IPAs are not liable for violations of the Prompt Pay Law, although an MCO contracting with an IPA appears to be subject to this law.⁴¹

³⁶ See 10 N.Y.C.R.R. § 98-1.18(a).

³⁷ See 10 N.Y.C.R.R. § 98-1.18(a).

³⁸ See 10 N.Y.C.R.R. § 98-1.18(f). This includes violations of Subpart 98-1, Article 28, Article 44, and Title I of Article 49 of the Public Health Law.

³⁹ See 10 N.Y.C.R.R. § 98-1.18(b).

⁴⁰ See 10 N.Y.C.R.R. § 98-1.18(d).

⁴¹ See *New York Health Plan Ass'n, Inc. v. Levin*, 187 Misc. 2d 527, 530 (Albany County Sup. Ct. 2001) ("The prompt pay law is clearly limited to payments by insurers or organizations or corporations licensed or certified pursuant to Article 43 of the Insurance Law or Article 44 of the Public Health Law. IPAs are not so licensed or certified. As such, there is no statutory authority for imposing sanctions directly upon IPAs for violations of the statute. . . . The regulation does not provide that the requirements of Article 44

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In fact, there is law indicating that MCOs and other insurers are still legally responsible for violations of the Prompt Pay Law relating to payment of claims even when they have contracted with an IPA for the provision of management services such as the payment of claims to providers.⁴² The law in this area is unclear, however, as there is also legal authority for the position that if the provider has “contractually agreed to look solely to a third party for payment,” the insurer or HMO is not ultimately responsible for the contractor’s payments in violation of the Prompt Pay Law.⁴³ What this means is that the terms of the contract between the IPA and MCO will have great significance in determining which entity is legally liable for certain functions and violations and that, if an IPA accepts legal responsibility through contract, that allocation of liability will likely be binding on the parties.

C. CONTRACTS BETWEEN MANAGED CARE ORGANIZATIONS AND INDEPENDENT PRACTICE ASSOCIATIONS

Contracts between IPAs and MCOs are scrutinized by the New York State Department of Health when an MCO applies for a certificate of authority. In addition to those requirements specific to IPA-MCO risk-sharing arrangements (see Section IV(A)), there are more legal requirements applicable to IPAs. Only IPAs that have met all of these legal requirements may contract with MCOs.

When an MCO applies to the State of New York for a certificate of authority to operate, it must include certain information with the initial application.⁴⁴ An MCO may not enroll individuals in a healthcare plan or deliver health services until it has a certificate of authority.⁴⁵ The application for a certificate of authority must include “a copy of any proposed contract or form of contract, and all attachments thereto” between the MCO and any provider(s) of covered services.⁴⁶ This requirement applies to IPA agreements and dictates that an MCO’s provider contracts contain certain provisions.

of the Public Health Law shall apply to an IPA to the same extent that they apply to HMOs. As such, it does not appear that there is any authority for sanctioning IPAs directly. In the absence of such authority, petitioners’ arguments would render the prompt pay law substantially unenforceable, clearly a result which was not intended by the Legislature.”).

⁴² See *Levin*, 187 Misc. 2d at 530-31 (“Moreover, the court credits respondents’ and intervenors’ argument that if respondents cannot enforce the prompt pay law against HMOs and insurers for violations of IPAs, there is no other currently authorized enforcement mechanism.”); Circular Letter No. 12, Section 3224-a Insurance Law and the Use of IPAs (Independent Practice Associations), State of New York Insurance Department, March 1, 2000 (available at http://www.dfs.ny.gov/insurance/circltr/2000/cl2000_12.pdf).

⁴³ New York General Counsel Opinion 2-13-2002, New York Insurance Bulletins and Related Materials (“[I]t is the position of this Department that New York Insurance Law § 3224-a [the Prompt Pay Law] does not require an insurer or HMO to be responsible to make payments to health care providers where the health care provider has contractually agreed to look solely to a third party for payment.”).

⁴⁴ See 10 N.Y.C.R.R. § 98-1.5(a).

⁴⁵ See 10 N.Y.C.R.R. § 98-1.5(a).

⁴⁶ See 10 N.Y.C.R.R. § 98-1.5(b)(6).

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The contract the MCO submits to the Department of Health must “specify any risk-sharing arrangements between the proposed MCO and the provider.”⁴⁷ Moreover, “[a]n MCO shall not enter into a contract” with a company “which proposes to provide the services of an (IPA) unless” certain requirements are met.⁴⁸ These requirements, as set forth in regulation, are described below.

1. The IPA’s Name Must Identify it as an IPA

The IPA’s certificate of incorporation or articles of organization must use the phrase “Independent Practice Association” or “IPA” in its legal name.⁴⁹ Those governing documents must also set out the requisite corporate powers and purposes allowing the IPA to arrange for the delivery or provision of health services through contracts between the IPA and providers and one or more MCOs.⁵⁰

2. The IPA’s Governing Document Must have Certain Limitations

The IPA’s governing document must specifically state that the IPA is not authorized to create or run a hospital, provide hospital or health-related services, operate a CHHA, hospice, MCO, or ACF, or to solicit contributions or grants for any similar purpose.⁵¹

3. The IPA May Only Exercise its General Powers as Outlined in Regulation

In addition, any general corporate powers authorized by an IPA’s certificate of incorporation or articles of organization must, by express provision in the governing document, be exercised “only as powers and purposes incidental to accomplishing the primary IPA powers and purposes”⁵² This means that any corporate powers that are otherwise authorized by law and that an IPA may choose to have must be expressly made subordinate to the IPA’s intended role vis-à-vis the MCOs.

4. The IPA’s Governing Documents Must be Reviewed and Filed

The last requirement is that the Insurance and Education Departments of the State of New York must review the IPA’s governing document, in addition to the Commissioner of the Department of Health.⁵³ The IPA’s governing document must also be filed with the Secretary of

⁴⁷ See 10 N.Y.C.R.R. § 98-1.5(b)(6)(i).

⁴⁸ See 10 N.Y.C.R.R. § 98-1.5(b)(6)(vii).

⁴⁹ See 10 N.Y.C.R.R. § 98-1.5(b)(6)(vii)(a).

⁵⁰ See 10 N.Y.C.R.R. § 98-1.5(b)(6)(vii)(a). The regulation states, “the certificate of incorporation or articles of organization of the IPA . . . contains powers and purpose permitting the arranging by contract for the delivery or provision of health services by individuals, entities and facilities licensed or certified to practice medicine and other health professions . . . by which arrangement such health care providers . . . will provide their services in accordance with and for such compensation as may be established by a contract between the IPA and one or more MCOs” *Id.*

⁵¹ See 10 N.Y.C.R.R. § 98-1.5(b)(6)(vii)(b).

⁵² See 10 N.Y.C.R.R. § 98-1.5(b)(6)(vii)(c).

⁵³ See 10 N.Y.C.R.R. § 98-1.5(b)(6)(vii)(d).

Chapter 2: IPAs

State, along with the waiver, approval, or consent of the Departments of Insurance and Education and the Commissioner of Health.

V. PRACTICAL OBSERVATIONS

Below are several practical insights regarding current issues, trends and questions that have come to our attention.

A. Provider Use of the Independent IPA Model

The independent IPA model is being used by providers throughout New York, often with great effectiveness. The most effective provider IPAs are being arranged by similar providers in the same industry and/or a “critical mass” of the providers in a geographic region. When a sufficient number of providers form an IPA, they form a group that the MCOs cannot ignore and must treat the IPA with more respect than any single member.

Providers are typically structuring these IPAs as: (1) traditional risk-sharing arrangements whereby the IPA facilitates the delivery of providers’ services to the MCO’s enrollees, or (2) offering management services to MCOs in addition to the traditional service delivery role. Providers using the traditional risk-sharing IPA method are often doing so as a way to better manage reimbursement rates as these providers are also contracting with the IPA individually as service providers. The pooling of providers significantly increases the leverage that they have in their negotiations with the MCOs regarding rates, however, there is a limit to this model. If providers try to join forces and refuse to provide services unless the MCOs agree to meet a minimum price, this will be seen as price fixing and a criminal antitrust violation. An IPA can exert influence on behalf of its members by giving those members more transparency and control over the rate negotiation process. This transparency and control can be used to legally counterbalance the leverage exerted by MCOs.

Those provider IPAs that contract for MCO management services in addition to the delivery of services are usually able to derive additional compensation from the provision of management services and/or manage important functions like utilization review, otherwise known as referral management. IPAs that are able to contract to perform management services for MCOs have stronger relationships with the MCOs and the ability to gain valuable insight into the MCO’s inner workings and the consumer population.

The proper use of the independent IPA model also creates greater integration and incentive to achieve the ultimate objective behind the IPA concept: more coordinated care, improved outcomes and greater cost efficiency. IPAs and member providers that are able to achieve these goals will reap financial rewards from risk sharing arrangements and increase their standing and leverage in the managed care community.

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B. Technical or Administrative Service Exception

While there is a high degree of regulation of the traditional IPA-MCO risk sharing arrangements and management service agreements, the provision of administrative and technical services are essentially unregulated. “Technical and administrative services” refers to any functions other than medical services and that an MCO is not prohibited from delegating⁵⁴ and that are not management services⁵⁵ requiring State approval. Administrative services include administrative expenses provided through a contract that the MCO would otherwise have reported on its cost report. Accordingly, this exception for technical and administrative services allows a fairly wide range of services that can be provided to the MCO under contract.

For instance, an MCO-IPA medical services contract can make the IPA responsible for provider credentialing because this is characterized as “technical or administrative.” Services like utilization review or claims adjudication or payment, on the other hand, are defined as management functions so these services can be the IPA’s responsibility but must be addressed in a management contract. One reason for this is the general requirement that provisions included in contracts between an MCO and an IPA, or between two IPAs, must be included in IPA contracts with providers.

This area is important to consider because it allows IPAs to be a more significant partner of MCOs by potentially providing administrative and technical services, in addition to management services and delivering healthcare services. This not only increases an MCO’s reliance on the IPA but it also offers increased revenue and greater control in the MCO-IPA relationship. IPAs that focus on becoming clinically integrated such that they ease operating burdens and increase efficiencies for their contracting partners will be in high demand. This greater integration and involvement by the IPA only enhances the likelihood of achieving greater care coordination, cost efficiency and improved outcomes – one of the primary motivations for any provider to enter into a risk sharing arrangement.

C. Can Providers Negotiate Managed Care Contracts?

A source of ongoing concern and confusion is whether providers can negotiate or request revisions to MCO and/or IPA contracts. We understand that some providers have been told by MCOs and IPAs that their contracts are not negotiable. These contracts can be modified, although more significant changes require Department of Health approval before they are effective. The Department of Health essentially dictates that certain concepts and provisions are essential to have included in these MCO and IPA agreements so any attempt to change these provisions would require the prior approval of the Department. Changes to language that is not dictated by law or that is of lesser significance can be made to these contracts without prior approval.

⁵⁴ See 10 NYCRR § 98-1.11(i).

⁵⁵ See 10 NYCRR § 98-1.11(j).

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According to law and the Department of Health guidance, “material amendments” to MCO and IPA contracts require the Department’s approval. Material amendments include the following:

1. Any change to a required contract provision;
2. Any change to or addition of a risk sharing arrangement - other than routine trending of fees or other reimbursement amounts;
3. The addition of an exclusivity, most favored nation, or non-compete clause;
4. Any proposed subcontracting of existing contractual obligations of an IPA;
5. Any proposed subcontracting of the statutory or regulatory responsibilities of an MCO; and
6. Any proposed revocation of an approved subcontract.

The Department’s guidance⁵⁶ describes the process for submitting material amendments to contracts. When material amendments to a contract between an MCO and IPA are being reviewed by the Department of Health, this contract must be submitted together with all related contracts between the IPA and providers. Contracts between two IPAs must be submitted together with all related MCO-IPA and IPA-provider contracts. The typical review horizon by the Department of Health is 90 days.

While prior approval of material amendments to these MCO and IPA contracts is required, this should not stop providers from requesting appropriate changes. In fact, material amendments to these contracts are being requested by some providers and approved by the Department, provided that they are appropriate and do not hinder the purpose, or policy, behind the legal requirements.

D. The “Messenger Model” IPA

The term “messenger model IPA” does not appear in any New York statute or regulation. This term likely derives from a 1996 statement of the United States Department of Justice and Federal Trade Commission, entitled “Statements of Antitrust Enforcement Policy in Health Care.”⁵⁷ The term appears in a discussion of networks that are not horizontally integrated with respect to price. As described, these networks “facilitate contracting between providers and payers and avoid price-fixing agreements among competing network providers.”⁵⁸ A description of possible “messenger models” appears in this document. In such a model, the IPA conveys information gathered from individuals to a payor, or offers objective advice to providers.

⁵⁶ See http://www.health.ny.gov/health_care/managed_care/hmoipa/guidelines.htm.

⁵⁷ Available at <http://www.justice.gov/atr/public/guidelines/0000.htm>.

⁵⁸ STATEMENTS OF ANTITRUST ENFORCEMENT POLICY IN HEALTH CARE, UNITED STATES DEPARTMENT OF JUSTICE AND FEDERAL TRADE COMMISSION, 1996, at 9.C (“Arrangements that Do Not Involve Horizontal Agreements on Prices or Price-Related Terms”).

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Such an arrangement does not appear to trigger any scrutiny in New York State, aside from that inherent in forming a corporate entity in New York, as it would not involve a contract between an MCO and an IPA.

Chapter 3: Home and Community-Based Services

New York State's Statewide Transition Plan for HCBS Settings

A five year plan to assure that all settings in which recipients of HCB services live and/or receive these services are fully compliant with 42 CFR 441.301(c)(4) and (5); 441.710(a)(1)(2)

Overview

On January 16, 2014, the Center for Medicare and Medicaid Services (CMS) published the final rule related to Home and Community Based Settings (HCBS) for Medicaid-funded long term services and supports provided in residential and nonresidential settings under the following authorities of the Social Services Act: 1915(c), 1915(i) and 1915(k). This rule implements a number of changes to home and community based waivers, finalizes regulatory changes to the 1915(i) state plan home and community based services and imposes new requirements on what is considered an appropriate home/community based residential setting for all the authorities in its scope. The crux of this final rule is to provide person-centered requirements which identify the strengths, preferences and needs (clinical and support), as well as the desired outcomes of the individual. The inclusion of defined HCBS setting requirements is one part of this strategy.

The final rule took effect March 17, 2014. States are required to submit transition plans to CMS within one year of the effective date indicating how they intend to comply with the new requirements within a reasonable time period. If states amend or renew any waivers or state plan amendments in place prior to the effective date, that action serves as a trigger for the state to submit a transition plan for all its waivers under 1915(c), as well as any state plan amendments under 1915(i) or 1915(k), within 120 days of the initial amendment/renewal submission.

The following is New York State's statewide transition plan pursuant to this requirement.

Background

New York State operates 12 1915(c) waivers across the four major offices that oversee programs and services to individuals who are aged and/or physically, behaviorally, mentally, developmentally or intellectually disabled. These agencies/offices are the Department of Health (DOH), Office of Mental Health (OMH), Office for People with Developmental Disabilities (OPWDD) and Office of Children and Family Services (OCFS). In addition, the Office for Alcohol and Substance Abuse Services (OASAS) provides services to some individuals in these waivers and participated in the development of the statewide transition plan. We do not currently offer services through our state plan under a 1915(i) or 1915(k) authority, although we have applied to CMS for approval of a 1915(k) Community First Choice Option state plan amendment.

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The following 1915(c) waivers are currently operating in New York State, the agency/office in parentheses operates the program under the oversight of the Department of Health, the state's single Medicaid Agency.

- Long Term Home Health Care Program Waiver (DOH)
- Nursing Home Transition and Diversion Waiver (DOH)
- Traumatic Brain Injury Waiver (DOH)
- Care at Home Waivers (I, II, III, IV, and VI) – (I and II, DOH; III, IV and VI, OPWDD)
- Bridges to Health (B2H) Waivers (B2H Serious Emotional Disturbances, B2H Developmental Disabilities and B2H
- Medically Fragile) (OCFS)
- Home and Community Based Services (HCBS) Waiver (OPWDD)
- SED (Serious Emotional Disturbances) Children's Waiver (OMH)

In addition, the above agencies/offices offer significant home and community based LTSS through our Medicaid state plan and DOH provides HCB services under the NY Partnership Plan 1115 Demonstration Waiver. The rule does not apply to state plan services outside of 1915(i) and 1915(k) authorities. However, CMS has indicated that it expects NYS to address the application of the HCB Settings rule to all HCB services provided through its 1115 Demonstration in this Statewide Transition Plan.

Most individuals receiving services through these waivers are living in their own homes or those of family members, certain group homes or other adult care facilities where they enjoy the qualitative benefits of receiving services in the community as opposed to in an institution. However, there are individuals who live in congregate housing, adult care facilities and supportive housing where their autonomy, independence and community integration may be less apparent, including children and youth where their rights are delegated to their parents or guardians.

New York has affirmed its commitment to serving individuals with disabilities in the least restrictive environment under Governor Andrew Cuomo's leadership. In 2012, the Governor introduced legislation to establish the Justice Center to ensure protection against abuse and neglect of individuals with special needs. The Justice Center became operational in 2013. Also in 2012, he convened the Olmstead Development and Implementation Cabinet, which met with over 160 stakeholder groups and reviewed over 100 position papers before releasing its report in October 2013. This report lays out recommendations for New York policymakers to continue efforts to ensure that individuals with disabilities are provided the services and supports they need that reflect their choice and support their goals to live an independent and fully integrated life in the community.

Consistent with these efforts, New York State convened an interagency workgroup in 2014 to address how best to comply with the requirements of the new settings rule. The

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group met regularly to ensure that a cohesive statewide transition plan was developed to address the unique needs of individuals across a wide variety of community-based settings. The interagency workgroup includes representatives from the Executive Chamber, DOH, OMH, OPWDD, OCFS, and OASAS. Five meetings were held between January and December to develop the transition plan that follows. This group will continue to meet to ensure full implementation of the plan and to work with stakeholders to carry out the assessment, remediation and ongoing monitoring activities in the plan.

Home and Community Based Setting Requirements

42 CFR §441.301(c)(4) and (5) requires that all settings in which individuals receiving Medicaid-funded home and community based services live and/or receive services must have the following characteristics and qualities:

(i) The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

(ii) The setting is selected by the individual from among setting options, including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.

(iii) Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.

(iv) Optimizes but does not regiment individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.

(v) Facilitates individual choice regarding services and supports, and who provides them. The rule imposes further requirements on settings that are provider owned or controlled. The following qualities and/or conditions must be assured in these settings:

(A) The unit or dwelling is a specific physical place that can be owned, rented or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord tenant law of the State, county, city or other designated entity. For settings in which landlord tenant laws do not apply, the State must ensure that a lease, residency agreement or other form of written agreement will be in place for each

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participant and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.

(B) Each individual has privacy in their sleeping or living unit:

(1) Units have entrance doors lockable by the individual, with only appropriate staff having keys to doors as needed.

(2) Individuals sharing units have a choice of roommates in that setting.

(3) Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.

(C) Individuals have the freedom and support to control their own schedules and activities, and have access to food at any time.

(D) Individuals are able to have visitors of their choosing at any time.

(E) The setting is physically accessible to the individual.

Finally, the rule asserts that hospitals, nursing homes, institutional care facilities (ICF) for the developmentally disabled and institutes for mental disease are not community-based settings. Further, settings on the grounds of public or private institutions and those in close proximity to public institutions are presumed to be institutional rather than community-based. New York State understands that it has the burden of providing evidence to the Secretary of Health and Human Services (HHS) if it believes that such a setting should be considered community-based for the purpose of allowing the provision of Medicaid-funded HCBS LTSS to individuals who reside there.

Summary of Activities to Develop Statewide Transition Plan (STP)

Assessment of State/Systemic Framework and Existing Settings

The NYS DOH, OMH, OPWDD, OCFS and OASAS staff assigned to the interagency workgroup reviewed existing state rules, regulations, provider qualifications, and practices to ensure that there were no systemic barriers to the implementation of the new HCB settings requirements. This review found the state framework to be consistent with the federal rule. (See letters attesting to this assertion, Appendix A).

Residential Settings

Staff reviewed the residential settings in which recipients of HCB services provided through the 1915(c) and 1115 waivers live and in the majority of cases found that participants live in their own home or family homes, which the state determines to be compliant with the rule. DOH and OMH determined that virtually all of their waiver participants live in fully compliant settings. The exceptions in the DOH TBI waiver are

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individuals who chose to live in a setting that may be partially compliant from among other options, which the regulation allows. There are no exceptions in the OMH SED waiver, which serves individuals between the ages of 5 and 17, all of whom reside in their family home.

OCFS notes that virtually all of its participants in the Bridges 2 Health Waivers live in family homes, however at any given time a number of participants may live in a congregate care foster home while awaiting placement in a family home. OCFS staff attest that these congregate settings have all the features one would find in a typical private home including kitchens with cooking facilities, community dining areas, living space for leisure time activities and bedrooms. Since the homes are located within the community there is ready access to activities and facilities available to the general population of the locale. The children are able to access and attend school within their communities, and utilize services fairly freely, and have the opportunity to build meaningful relationships with community members and community organizations.

While the majority of participants in all waivers live in fully compliant settings, the largest number of individuals in partially compliant settings are participants in the 1915(c) HCBS Waiver operated by the OPWDD. OPWDD has developed and vetted a specific HCBS settings transition plan to submit with its HCBS Waiver renewal, anticipated to be resubmitted to CMS in 2015. Its components that are consistent with the statewide efforts are reflected in the Statewide Transition Plan (Appendix C); OPWDD's Transition Plan has further detail on planned activities unique to its system.

Non-residential settings

New York State's waiver participants receive HCB services both in their own homes and in the community. Some settings in which services are provided may not be fully compliant with the new federal rule. As part of the Statewide Transition Plan, New York's agencies and offices operating 1915(c) and/or 1115 waivers will assess non-residential settings through provider and participant surveys, validating self-assessment with statistically significant site visits by state or local staff, plan staff or other entities (i.e. contractors, consumer advocacy organizations).

Remedial Strategies

While the vast majority of waiver participants reside in compliant settings, the interagency workgroup recommended that remedial strategies include (1) ensuring that providers and participants are aware of the requirements and (2) that monitoring procedures and practices ensure that they are fully implemented in residential and non-residential settings in which recipients of HCB services funded by Medicaid live and/or receive services. In addition, the state has a significant role to play in assuring that the intent of the rule is carried out consistently across the state by the myriad of providers, local agencies,

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managed care and managed long term care plans and other entities providing services to HCB service recipients.

Toward that end, the interagency workgroup will continue to meet and will work with stakeholders to develop guidance documents and other means to assure full compliance and a smooth implementation process.

This will also be the venue for the development of survey and evaluation tools to assess the appropriateness of nonresidential settings and initial and ongoing compliance with the federal rule. Stakeholders will be involved in this process, as well, to assure that developed tools allow providers to effectively self-assess their settings to assure the presence of the qualities and characteristics of allowable HCB Settings.

The state will validate provider self-assessments using developed evaluation tools by deploying state or local staff, managed care organizations, long term care ombudsmen, contractors, HCB service recipients and/or consumer advocacy organizations to a statistically significant number of sites for compliance reviews.

Monitoring for Ongoing Compliance

New York State currently employs a variety of quality assurance and monitoring practices to meet the terms and conditions of its current 1915(c) and 1115 waivers. The state assures that these practices will be amended to include ensuring that the settings where recipients of HCB services and supports live and/or receive services comply with the requirements of the federal rule. This will be accomplished through guidance developed by the interagency workgroup with stakeholder input and implemented both through site visits and the person-centered service planning process. The Assessment of Residential Settings Chart (Appendix B) includes the timing of planned site visits and the Statewide Transition Plan Timeline (Appendix C) includes timeframes for the development of additional monitoring activities for both residential and non-residential settings.

Public Input

Initial Plan

The State developed its initial draft Statewide Transition Plan between March and June of 2014. This plan was published on a page devoted to the Home and Community Based Services Settings Rule on the State website on June 26, 2014 at http://www.health.ny.gov/health_care/medicaid/redesign/home_community_based_settings.htm. Subsequently, two Webinars were held in July to inform interested parties across the state of the requirements of the federal rule and the State's efforts to date to develop a transition plan. The identical presentations and a recorded version of the first session were posted and remain available on the website. This page also allows stakeholders

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and the general public electronic access the final rule published in the Federal Register on January 16, 2014.

In addition, the State published a notice about the draft Statewide Transition Plan in the August 27, 2014 State Register at

<http://docs.dos.ny.gov/info/register/2014/august27/pdf/misc.pdf>.

Finally, staff at each of the agencies/offices operating waivers under 1915(c) and 1115 of the Social Security Act included information about the federal rule, its impact and the state's proposed transition plan in numerous presentations to stakeholder groups, including recipients of HCB services and supports and their representatives, across the state.

Summary and Disposition of Public Comments

Five organizations submitted written comments to the State regarding the statewide transition plan. In addition, many organizations, providers and recipients provided feedback to OPWDD based on its public forums and other stakeholder information sessions regarding its HCBS Waiver Transition plan, which is included in the Statewide Transition Plan and detailed in Appendix A.

The comments specific to the draft statewide transition plan are summarized here. Generally, organizations felt that:

- the proposed transition plan is too vague,
- it lacks stakeholder involvement in its development and implementation, and
- it pushes compliance too far into the future.

The State agrees that the initial plan did not include the specific assessment, remediation and monitoring milestones, timeframes and deliverables that CMS guidance released in late Spring noted was expected to be included in plans submitted for approval. Accordingly, the revised statewide transition plan includes these components.

To address concerns about the lack of stakeholder involvement in the initial plan, the revised plan calls for a significant role for stakeholders in developing survey and evaluation tools and participating in the implementation of the specified activities to achieve full compliance in all settings across the state.

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Finally, the State has amended the state plan to better define the actions we will take to achieve compliance while providing ample time for providers to implement necessary changes.

To view, visit

https://www.health.ny.gov/health_care/medicaid/redesign/hcbs_statewide_transition_plan_final.htm.

***Chapter 4: Home and Community Based Services Provider
Manual***

Provider Manual
Starts on Next Page



September 18, 2014

Dear Provider,

The New York State Home and Community Based Services (HCBS) provider manual for 1915i services is now available electronically on the website of the New York State Office of Mental Health www.omh.ny.gov, the New York State Office of Alcoholism and Substance Abuse Services www.oasas.ny.gov and the New York State Department of Health http://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health_transition.htm.

Health and Recovery Plan (HARP) eligible enrollees will have the ability to access an enhanced benefit that includes an array of HCBS services. All programs wishing to provide HCBS must apply to be designated for each service they propose to offer and attest to meeting the staffing and service delivery criteria as outlined in the manual. Applications must be submitted via an online portal on the OMH website that will be available beginning in October. Additional guidance will be available shortly. All New York City provider applications must be filed on or before December 5, 2014, but applicants are encouraged to submit prior to that date. Applications for the rest of the state may be submitted at this time, however official provider designation for areas outside of the New York City service area will not be made at this time. Additional guidance will follow concerning the application deadlines for the rest of the state.

HARPs will utilize the HCBS to provide opportunities for Medicaid beneficiaries with mental illness and/or substance use disorders to receive person-centered recovery services in their own community. HARPs will have specialized staffing qualifications and network adequacy requirements, along with focused behavioral health performance metrics. In order to participate in a HARP's network, programs must be designated as eligible to provide HCBS.

New York seeks stakeholder comments/questions on this HCBS Manual. Please be advised that the service definitions described in the manual are subject to change based on The Centers for Medicare and Medicaid Services (CMS) approval of the 1115 waiver. A separate billing manual outlining the reimbursement rates and billing codes will be available in October. Please submit any comments/questions on the HCBS manual electronically to BHO@OMH.ny.gov.

Thank you for your efforts to assist NYS in transitioning behavioral Health services to a person-centered, community-based system that supports recovery.

Sincerely,

Robert Myers, Senior Deputy Commissioner, NYS Office of Mental Health

Robert Kent, General Counsel, NYS Office of Alcoholism and Substance Abuse Services

Greg Allen, Director, Division of Program Development and Management

cc: G. Weiskopf
D. Zalucki
E. DeLorenzo

New York State: Health and Recovery Plan (HARP) Home and Community Based Services (HCBS) Provider Manual

New York State is pleased to release the initial version of the Home and Community Based Services (HCBS) Manual that will be used as a basis to begin the HCBS designation process. The Office of Mental Health (OMH), Office of Alcoholism and Substance Abuse (OASAS) and the Department of Health (DOH) are open to stakeholder input on the established service standards as the 1115 waiver amendment is being negotiated with the Centers for Medicaid and Medicare Services (CMS). This manual is subject to change based upon the final terms and conditions approved by CMS. All comments should be submitted electronically to BHO@omh.ny.gov.

The HCBS manual describes the basic requirements for any entity that is interested in providing HCBS behavioral health services within New York's public behavioral health system. These entities may include:

- Behavioral health contracted and non-contracted providers, including those that provide rehabilitation, employment, community-based treatment, peer support, and crisis services;
- State entities providing behavioral health services, including mental health and/or substance use disorder services; or other organizations or clinicians that meet criteria;
- Hospitals providing specialized behavioral health services;
- Licensed/ Certified residential, inpatient and organizations providing mental health and/or substance use disorder clinical services; and
- Programs that are currently providing outreach, peer, vocational, or rehabilitative services to people with substance use disorders (SUD) that are funded through Alternatives to Incarceration, Ryan White Federal funding, or funding from Department of Health and Mental Hygiene, NYC Department of Health or the AIDS Institute.

The HCBS Services Manual includes information regarding services that are allowable and reimbursable as approved by CMS. This information, includes service definitions and service requirements reflective of documents that were developed in accordance with Medicaid policies and protocols and submitted for approval. A separate billing manual outlining the reimbursement rates and billing codes will be available in October. Specifically, the HCBS Services Manual outlines the following:

1. Services Definitions & Descriptions
2. Provider Qualifications
3. Eligibility Criteria
4. Limitations/Exclusions
5. Allowed Modes of Delivery
6. Additional Service Criteria
7. Practitioner credentials for service provision
8. HCBS Services that may be provided together (HCBS clusters)
9. Sample attestation forms

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I. Introduction

The Centers for Medicare and Medicaid Services (CMS) has authorized various home and community based services (HCBS) under their Medicaid waiver authority. HCBS services were initially established in an effort to keep individuals out of hospitals, nursing homes or other institutions. Recipients had to be evaluated and assessed to meet an institutional level of care, i.e., they could be admitted to an institution if not for the availability of an HCBS waiver program. A person served in a HCBS waiver must be assessed using a validated comprehensive assessment tool to determine their treatment, rehabilitation and support needs. A comprehensive, person centered plan of care is then developed and the person is then connected to appropriate services. The care plan must be developed in a “conflict free” manner, meaning the person conducting the assessment and developing the plan of care cannot direct referrals for service only to their agency or network. The person must have choice among available providers. New York State is working with CMS to determine how appropriate checks and balances will be established to meet this conflict free requirement for the 1915i HCBS HARP benefit.

The CMS also requires state oversight to determine: that the assessment is comprehensive, the planning process is person-centered and addresses services and support needs in a manner that reflects individual preferences and goals, the services were actually provided, and the person is assessed at least annually or when there is a change in condition (e.g., loss of housing, inpatient admission, etc.) to appropriately reflect service needs. CMS also requires assurances which the state, managed care plans and providers must monitor and report on to assure people enrolled in HCBS waivers are receiving appropriate services.

On March 17, 2014 CMS issued the Final HCBS Rule that established, upon other provisions, conformity across HCBS authorities for person-centered planning and allowable settings. The rule states that HCBS services can only be provided in settings which are considered integrated community settings. New York State is reviewing these rules to determine how this will be addressed in certain housing, residential and day programs.

Section 1915i of the Social Security Act was established as part of the Deficit Reduction Act of 2005. 1915i afforded States the opportunity to provide HCBS under the Medicaid State Plan without the requirement that Medicaid members need to meet the institutional level of care as they do in a 1915(c) HCBS Waiver. The intent is to allow and encourage states to use the flexibility of HCBS services to develop a range of community based supports, rehabilitation and treatment services with effective oversight to assure quality. These services are designed to allow individuals to gain the motivation, functional skills and personal improvement to be fully integrated into communities. The 1915i option acknowledges that even though people with disabilities may not require an institutional level of care (e.g. hospital, nursing home) they may still be isolated and not fully integrated into society. This isolation and lack of integration may have been perpetuated by approaches to service delivery which cluster people with disabilities, and don't allow for flexible, individualized services or services which promote skill development and community supports to overcome the effects of certain disabilities or functional deficits, motivation and empowerment.

The CMS allows states to include the flexibility of 1915i state plan services in Medicaid Managed care 1115 waivers. New York State has chosen to include 1915i like HCBS services in its 1115 waiver amendment for behavioral health. The inclusion of these HCBS services will give NYS managed care provider networks and most importantly, enrollees in managed care, a new range of

HCBS services in their benefit package. These services are designed to help overcome the cognitive and functional effects of behavioral health disorders and help individuals with behavioral health conditions to live their lives fully integrated into all aspects of their community.

The addition of these services to the benefit package will also assist NYS to meet the requirements of the Americans with Disabilities Act and the Olmstead Law. The primary goal is to create a supportive and empowering environment for people with behavioral health conditions to live productive lives within our communities.

The provider manual describes these services in detail and the requirements for providers' participation. We look forward to working with managed care plans and provider networks to transform our system of care to one that supports rehabilitation and recovery from behavioral health conditions.

II. Values/Core Principles

The past 30 years have seen a transformation of the public mental health system. The State-operated adult psychiatric hospital census has declined from over 20,000 to under 2,900. Access to outpatient treatment, community supports, rehabilitation, and inpatient psychiatric services at general hospitals have expanded. More than 38,000 units of state supported community housing for people living with mental illness have been developed. These community based resources have created a safety net which has helped the mental health system to evolve from a primarily hospital focused system to one of community support. The emergence of the peer recovery and empowerment movement in the 1990s has stimulated the shift in focus from support to recovery. The legal system's expansion of civil rights to include people with mental illness, as part of Olmstead Legislation and Americans with Disabilities Act, has begun to move policy from the concept of least restrictive setting to full community inclusion.

In 2008, New York State initiated detox reform that reduced incentives for unnecessary hospital detox and began the process of building community and ambulatory access to withdrawal symptom management for SUD patients who do not require a hospital level of care for safely discontinuing the use of substances. OASAS initiated ancillary withdrawal services to allow for the management of mild to moderate withdrawal symptoms in outpatient and inpatient settings. The goal will include access to medically supervised withdrawal management in all levels of care for symptom management where there is very low risk of medical complications of withdrawal. SUD individuals will be able to access treatment in the lowest level of care necessary to support long-term recovery.

The development of Health and Recovery Plans (HARPs) is intended to promote significant improvements in the Behavioral Health System as we move into a recovery-based Managed Care delivery model. A recovery model of care emphasizes and supports a person's potential for recovery by optimizing quality of life and reducing symptoms of mental illness and substance disorders through empowerment, choice, treatment, educational, vocational, housing, and health and well-being goals. Recovery is generally seen in this approach as a personal journey rather than a set outcome, and one that may involve developing hope, a secure base and sense of self, supportive relationships, self-direction, social inclusion, and coping skills.

The 1915(i) HCBS provide opportunities for Medicaid beneficiaries with mental illness and/or substance use disorders to receive services in their own home or community. Implementation of the Home and Community Based Services will help to create an environment where managed care

plans, service providers, plan members, families, and government partner to help members prevent and manage chronic health conditions and recover from serious mental illness and substance use disorders. The partnership will be based on these core principles:

Person-Centered Care: Services should reflect an individual's goals and emphasize shared decision-making approaches that empower members, provide choice, and minimize stigma. Services should be designed to optimally treat illness and emphasize wellness and attention to the persons overall well-being and full community inclusion.

Recovery-Oriented: Services should be provided based on the principle that all individuals have the capacity to recover from mental illness and/or substance use disorders. Specifically, services should support the acquisition of living, vocational, and social skills and be offered in home and community-based settings that promote hope and encourage each person to establish an individual path towards recovery.

Integrated: Services should address both physical and behavioral health needs of individuals. Care coordination activities should be the foundation for care plans, along with efforts to foster individual responsibility for health awareness.

Data-Driven: Providers should use data to define outcomes, monitor performance, and promote health and well-being. Performance metrics should reflect a broad range of health and recovery indicators beyond those related to acute care.

Evidence-Based: Services should utilize evidence-based practices where appropriate and provide or enable continuing education activities to promote uptake of these practices.

Trauma-Informed: Trauma-informed services are based on an understanding of the vulnerabilities or triggers experienced by trauma survivors that may be exacerbated through traditional service delivery approaches so that these services and programs can be more supportive and avoid re-traumatization. All programs should engage all individuals with the assumption that trauma has occurred within their lives. (SAMHSA, 2014)

Peer-supported: Peers will play an integral role in the delivery of services and the promotion of recovery principles.

Culturally Competent: Culturally competent services that contain a wide range of expertise in treating and assisting people with Serious Mental Illness (SMI) and Substance Use Disorder (SUD) in a manner responsive to cultural diversity.

Flexible and mobile: Services should adapt to the specific and changing needs of each individual, using mobile service delivery approaches along with therapeutic methods and recovery approaches which best suit each person.

Inclusive of Social Network: The person, and when appropriate, family members and other key members of the person's social network are always invited to initial meetings, or any necessary meetings thereafter to mobilize support.

Coordination and collaboration: These characteristics should guide all aspects of treatment and rehabilitation to support effective partnerships among the individual, family and other key natural supports and service providers.

III. Eligibility and Enrollment

HARP enrollment will be open to Medicaid beneficiaries with serious mental illness and/or substance use disorders. Individuals identified as HARP eligible must be offered care management through State-designated Health Homes. An initial cohort of individuals have been identified as HARP eligible based on their utilization of behavioral health services. This cohort has been shared with mainstream managed care plans for their members and with Health Homes to begin the process of engaging HARP eligible members in care management. Going forward, HARP eligible members will be identified by the State on an ongoing basis and shared with the HARP Plans, which will make assignments to Health Homes. Individuals can also be referred to HARP plans. HARP members will be required to be assessed for HCBS eligibility using an HCBS eligibility tool that contains items from the NYS Community Mental Health Suite of the InterRAI Functional Assessment. The eligibility assessment tool will determine if an individual is eligible for Tier 1 or Tier 2 services. Tier 1 services include employment, education and peer supports services. Tier 2 includes the full array of 1915i-like services. If HCBS eligibility is determined based on the initial assessment, then the full NYS Community Mental Health Suite of the InterRAI will be completed and a Plan of Care developed. Once completed, a Health Home Care Manager will work in collaboration with the individual and identify the HCBS services that will be included in the plan of care. At least one HCBS service must be included on the plan of care for eligible individuals. If the individual does not meet the functional need for 1915i-like services through the HARP/HCBS eligibility tool, the Plan of Care cannot include 1915i-like services. Re-assessment for HCBS eligibility will be conducted on an annual basis, or after a significant change in the member's condition such as an inpatient admission or a loss of housing. Health Homes will provide care management and will have a role in the assessment of individuals for HCBS services. Provider agencies will deliver the HCBS services as described in this manual.

Adjustment Authority:

The state will notify CMS and the Public at least 60 days before exercising the option to modify needs-based eligibility criteria in accord with 1915 (i).

IV. Person-Centered Planning and Service Delivery

Based on an independent assessment of functioning and informed by the individual, the written service plan must meet the following requirements:

1. The service plan must include services chosen by the individual to support independent community living in the setting of his or her own choice and must support integration in the community, including opportunities to seek employment, engage in community life, control personal resources, and to receive services within the community;
2. Include the individual's strengths and weaknesses;
3. Be developed to include clinical and support needs that are indicated by the independent functional assessment;
4. Be comprised of goals and desired outcomes that are chosen by the individual;
5. Include services and supports (paid by Medicaid, natural supports and other community supports) that will enable the individual to meet the goals and outcomes identified in the service plan;
6. Identification of risk factors and barriers with strategies to overcome them;
7. Be written in a way that is clearly understandable by the individual;
8. Include the individual and the entity that is responsible for the oversight of the plan of care implementation, review of progress and need for modifications if desired outcomes are not being met or the individual's needs change;

9. Include an informed consent of the individual in writing along with signatures of all individuals responsible for the plan implementation;
10. Be sent to all of the individuals and others involved in implementing and monitoring the plan of care; and
11. The plan should not include services that are duplicative, unnecessary or inappropriate.

V. HCBS Service Definitions

Psychosocial Rehabilitation (PSR)

Definition

PSR services are designed to assist the individual with compensating for or eliminating functional deficits and interpersonal and/or environmental barriers associated with their behavioral health condition (i.e., SUD and/or mental health). Activities included must be intended to achieve the identified goals or objectives as set forth in the individual's Recovery Plan. The intent of PSR is to restore the individual's functional level to the fullest possible (i.e., enhancing SUD resilience factors) and as necessary for integration of the individual as an active and productive member of his or her family, community, and/or culture with the least amount of ongoing professional intervention.

Service Components

This service may include the following components:

- Rehabilitation counseling including recovery activities and interventions that support and restore social and interpersonal skills necessary to increase or maintain community tenure, enhance interpersonal skills, establish support networks, increase community awareness, develop coping strategies and effective functioning in the individual's social environment such as home, work, and school including:
 - Independent Living: A close working relationship between staff and participant to develop and strengthen the individual's independent community living skills and support community integration
 - Social: Establishing and maintaining friendships and a supportive recovery social network, developing conversation skills and a positive sense of self; coaching on interpersonal skills and communication; training on social etiquette; relapse prevention skills; identify trauma triggers; develop anger management skills; engender civic duty and volunteerism
 - Community: Support the identification and pursuit of personal interests (e.g. creative arts, reading, exercise, faith-based pursuits, cultural exploration); identify resources where these interests can be enhanced and shared with others in the community; identify and connect with natural supports and recovery resources, including family, community networks, and faith-based communities
- Rehabilitation, counseling, recovery activities, interventions and support with skills necessary for the individual to improve self-management of and reduce relapse to substance use, the negative effects of psychiatric, or emotional symptoms, that interfere with a person's daily living, and daily living skills that are critical to remaining in home, school, work, and community. Rehabilitation counseling and support necessary for the individual to implement learned skills so the person can remain in a natural community location including:
 - Personal autonomy: Learning to manage stress, unexpected daily events and disruptions, mental health symptoms, relapse triggers and cravings with confidence; develop and pursue leisure and recreational interests, manage free time

- comfortably; transportation navigation
- Health: Developing constructive and comfortable interactions with health-care professionals, Relapse Prevention Planning (Individual Recovery Plan); managing chronic medical conditions, mental health symptoms and medications; establishing good health routines and practices
- Social Skills: Engaging with people respectfully, appropriate eye contact, conversation skills, listening skills and advocacy skills
- Wellness: meal planning, healthy shopping and meal preparation, nutrition awareness, exercise options
- Personal care: grooming, maintaining living environment, managing finances and other independent living skills
- Rehabilitation counseling including recovery activities, interventions and support necessary for the individual to implement learned skills so the person can remain in a natural community location
- Assisting the individual with effectively learning adaptive behaviors responding to or avoiding identified precursors such as cravings or triggers that result in relapse or functional impairments

Ongoing assessment of the individual's progress toward recovery, functional skill and impairment levels that is used to select PSR interventions and periodically assess their effectiveness in achieving goals.

Modality

PSR is a face-to-face intervention with the individual who has a behavioral health (i.e., SUD/ Mental Health) diagnosis

Setting

- Services must be offered in the setting best suited for desired outcomes, including home, or other community-based setting in compliance with Medicaid regulations. The setting may include programs that are peer driven/operated or peer informed and that provide opportunities for drop-in.
- Services may be provided individually or in a group setting and should utilize (with documentation) evidence-based rehabilitation and recovery. The program should utilize all goal-directed individual and group task to meet the goals identified above.
- On or off site.

Admissions/Eligibility Criteria

An individual must have the desire and willingness to receive rehabilitation and recovery services as part of their individual recovery plan, with the goal of living their lives fully integrated in the community and, if applicable, to learn skills to support long-term recovery from substance use through independent living, social support, and improved social and emotional functioning.

Limitations/Exclusions

These services may complement, not duplicate, services aimed at supporting an individual to achieve an employment-related goal in their plan of care. The total combined hours for Psychosocial Rehabilitation and Community Psychiatric Support and Treatment are limited to no more than a total of 500 hours in a calendar year.

Certification/Provider Qualifications

Providers of service may include non-licensed behavioral health staff (see appendix). Workers who provide PSR services should periodically report to a supervising licensed practitioner on participants' progress toward the recovery and re-acquisition of skills.

Staffing Ratio/Case Limits

Staff to Member Ratio: 1:20.

Community Psychiatric Support and Treatment (CPST)

Definition

CPST includes time-limited goal-directed supports and solution-focused interventions intended to achieve identified person-centered goals or objectives as set forth in the individual's Plan of Care and CPST Individual Recovery Plan.

The following activities under CPST are designed to help persons with serious mental illness to achieve stability and functional improvement in the following areas: daily living, finances, housing, education, employment, personal recovery and/or resilience, family and interpersonal relationships and community integration. CPST is designed to provide mobile treatment and rehabilitation services to individuals who have difficulty engaging in site-based programs who can benefit from off-site rehabilitation or who have not been previously engaged in services, including those who had only partially benefited from traditional treatment or might benefit from more active involvement of their family of choice in their treatment.

Service Components

The service may include the following components to meet the needs of the individuals with mental health and/or a substance use diagnosis:

- Assist the individual and family members or other collaterals to identify strategies or treatment options associated with the individual's mental illness, with the goal of minimizing the negative effects of mental illness symptoms or emotional disturbances or associated environmental stressors which interfere with the individual's daily living, financial management, housing, academic and/or employment progress, personal recovery or resilience, family and/or interpersonal relationships, and community integration
- Provide individual and their family supportive counseling, solution-focused interventions, emotional and behavioral management, and problem behavior analysis with the individual, with the goal of assisting the individual with social, interpersonal, self-care, daily living, and independent living skills to restore stability, to support functional gains and to adapt to community living
- Facilitate participation in and utilization of strengths based planning and treatments which include assisting the individual and family members or other collaterals with identifying strengths and needs, resources, natural supports, and developing goals and objectives to utilize personal strengths, resources, and natural supports to address functional deficits associated with their mental illness
- Assist the individual with effectively responding to or avoiding identified precursors or triggers that would risk their remaining in a natural community location, including assisting the individual and family members or other collaterals with identifying a potential psychiatric or personal crisis, developing a crisis management plan and/or as appropriate, seeking other supports to restore stability and functioning
- Provide ongoing rehabilitation support for individuals pursuing employment, housing, or education goals. Assist the individual with independent living skills to promote recovery and growth specific to managing their own home including managing their money, medications, and using community resources and other self-care requirements
- Implement interventions using evidence-based and best practice techniques, drawn from cognitive-behavioral therapy and other evidence-based psychotherapeutic interventions that ameliorate targeted symptoms and/or recover the person's capacity to cope with or prevent symptom interference with daily activities.

Modality

CPST is a face-to-face intervention with the individual, family or other collaterals.

Setting

- Services must be offered in the setting best suited for desired outcomes, including home or other community-based setting.
- Off site

Admissions/Eligibility Criteria

CPST services are intended to help engage individuals with mental health and/or a substance use diagnosis who are unable to receive site-based care or who may benefit from community based services including those who had only partially benefited from traditional treatment or might benefit from more active involvement of their family in their treatment. In addition, this service is intended for individuals who are being discharged from inpatient units, jail or prisons, and with a history of non-engagement in services, transitioning from crisis services, and for people who have disengaged from care.

Limitations/Exclusions

Community treatment for eligible individuals can continue as long as needed, within the limits, based on the individual's needs. The intent of this service is to eventually transfer the care to a place based clinical setting.

The total combined hours for CPST and Psychosocial Rehabilitation (PSR) and are limited to no more than a total of 500 hours in a calendar year.

Certification/Provider Qualifications

- Agencies who have experience providing similar services should already have a license to provide treatment services (i.e., Clinics, PROS, Intensive Psychiatric Rehabilitation Treatment (IPRT), Partial Hospitalization, Comprehensive Psychiatric Emergency Programs (CPEP), or currently utilize an evidence based or best practice off-site treatment model using licensed professionals.
- Licensed staff (see appendix) must provide this service.

Staffing Ratio/Case Limits

Decisions about how to balance caseloads will be left to the provider agencies as they see appropriate to ensuring quality of care and maintaining acceptable performance outcomes.

Habilitation/Residential Support Services

Definition

Habilitation services are typically provided on a 1:1 basis and are designed to assist participants with a behavioral health diagnosis (i.e. SUD or mental health) in acquiring, retaining and improving skills such as communication, self-help, domestic, self-care, socialization, fine and gross motor skills, mobility, personal adjustment, relationship development, use of community resources and adaptive skills necessary to reside successfully in home and community-based settings.

These services assist participants with developing skills necessary for community living and, if applicable, to continue the process of recovery from an SUD disorder. Services include things such as: instruction in accessing transportation, shopping and performing other necessary activities of community and civic life including self-advocacy, locating housing, working with landlords and roommates and budgeting. Services are designed to enable the participant to integrate full into the community and endure recovery, health, welfare, safety and maximum independence of the participant.

Service Components

- Habilitation/Residential Support services may help participants develop skills necessary for community living and recovery with ongoing assessment of participants' functional status and development of rehabilitative goals, such as:
 - Instruction in accessing and using community resources such as transportation, translation, and communication assistance as identified as a need in the plan of care and services to assist the participant in shopping and performing other necessary activities of community and civic life, including self-advocacy; for example, coordinating and helping to secure TTY services, language bank services, or other adaptive equipment needs
 - Instruction in developing or maintaining financial stability and security (e.g., understanding budgets, managing money, and the right to manage their own money). Assistance in developing financial skills through instruction of budget development, money management skills, and self-direction with regards to managing own funds and relapse triggers. (Specifically, if a resident has a representative payee, one goal must be to develop skills to manage more independently)
 - Skill training and hands-on assistance of instrumental activities of daily living, including assistance with shopping, cooking, cleaning, and other necessary activities of community and civic living (voting, civic engagement via community activities, volunteerism)
 - Habilitation/Residential Supports provide onsite modeling, training, and/or supervision to assist the participant in developing maximum independent functioning in community living activities. The on-site modeling, cueing, and /or instruction and support may assist participant in developing maximum independent problem-solving, interpersonal, communication, and coping skills, including relapse prevention planning, integration/adaptation to home/community, on-site symptom monitoring, and self -management of symptoms
 - Facilitation of family reunification through coordination of family services as applicable and self-advocacy instruction. The goal would be to facilitate communication with family members/natural supports to encourage the development of recovery support plans, i.e., medication compliance, ADL skills, and functional changes
 - Housing preservation and advocacy training, including assistance with developing positive landlord-tenant relationships, and accessing appropriate legal aid services if needed including skills to successfully live with roommates

- Assistance with developing strategies and supportive interventions for avoiding the need for more intensive services such as inpatient detoxification, coordinating crisis services, and consulting with current service providers (including SUD providers, mental health providers, health care providers, family-friends-natural supports, parole-probation-drug courts, state vocational rehabilitation services and other stakeholders) to develop a plan for intervention
- Assistance with increasing social opportunities and developing social support skills that ameliorate life stressors resulting from the participant's disability and promote health, wellness and recovery. For example, helping a participant to connect to community-based organizations based on participants' identified interests that are available to the public and promote recovery and social integration
- Instruction in self-advocacy skills including activities designed to facilitate participants' ability to access social service systems (health care, substance abuse, employment, vocational rehabilitation, entitlements/benefits, self-help groups) and other recovery-oriented systems of care are included
- Instruction in developing strategies to manage trauma induced behaviors and/or PTSD as per a Trauma Informed Assessment

The cost of transportation provided by residential service providers to and from activities is included as a component within the rate of the residential service. Providers of residential services are responsible for the full range of transportation services needed by the participants they serve to participate in services and activities specified in their recovery-oriented service plan. This includes transportation to and from recovery-oriented services and employment services, as applicable.

Modality

Habilitation/Residential Support Services are face-to-face services and may be delivered individually or in a group.

Setting

Habilitation/Residential Support Services may be delivered in a home (on-site), or in the community (off-site) and may be provided by the provider of housing services of the individual.

Admissions/Eligibility Criteria

An Individual requires residential support, rehabilitation, and onsite services that may include, but are not limited to: cognition (cognitive skills), functional status (ADL), and recovery-oriented community support.

Limitations/Exclusions

The total combined hours for Habilitation and Residential Supports/Supported Housing are limited to no more than a total of 250 hours in a calendar year. Time limited exceptions to this limit for individuals transitioning from institutions are permitted if prior authorized and found to be part of the cost-effective package of services provided to the individual compared to institutional care.

Certification/Provider Qualifications

Non-licensed Staff (see appendix) may provide this service.

Staffing Ratio/Case Limits

- Staff ratio of 1:15 or less (1 Direct Care staff to 15 participants to provide individual, and group residential supports services).
- Supervisory ratio: 1:5 (1 supervisor to 5 Direct Care Staff).

Family Support and Training

Definition

Training and support necessary to facilitate engagement and active participation of the family in the treatment planning process and with the ongoing implementation and reinforcement of skills learned throughout the treatment process. This service is provided only at the request of the individual. A person-centered or person-directed, recovery oriented, trauma-informed approach to partnering with families and other supporters to provide emotional and information support, and to enhance their skills so that they can support the recovery of a family member with a substance use disorder/mental illness. The individual, his or her treatment team and family are all primary members of the recovery team.

For purposes of this service, “family” is defined as the persons who live with or provide care to a person served on the waiver and may include a parent, spouse, significant other, children, relatives, foster family, or in-laws. “Family” does not include individuals who are employed to care for the participant.

Training includes instruction about treatment regimens, elements, recovery support options, recovery concepts, and medication education specified in the Individual Recovery Plan and shall include updates, as necessary, to safely maintain the participant at home and in the community. All family support and training must be included in the individual’s recovery plan and for the benefit of the Medicaid covered participant.

Service Components

Allowable activities include:

- Training on treatment regimens including elements such as: recovery support options, recovery concepts and medication education and use of equipment
- Assisting the family to provide a safe and supportive environment in the home and community for the individual (e.g., coping with various behavior challenges, understanding Substance use disorder, psychotherapy, and behavioral interventions)
- Provide one-on-one and group counseling
- Facilitate family and friends support groups under the direction of a certified peer
- Provide family mediation and conflict resolution services
- Development and enhancement of the family’s specific problem-solving skills, coping mechanisms, and strategies for the individual’s symptom/behavior management and prevention of relapse. This includes providing tools on problem solving and coping skills and strategies
- Collaboration with the family and caregivers in order to develop positive interventions to address specific presenting issues and to develop and maintain healthy, stable relationships among all caregivers, including family members, in order to support the participant’s recovery. Emphasis is placed on the acquisition of coping skills by building upon family strengths
- Assisting the family in the acquisition of knowledge and skills necessary to understand and address the specific needs of the Medicaid eligible individual in relation to their substance use disorder/mental illness and treatment
- Provide family with training/workshops on topics including recovery orientation and advocacy, psycho-education, person-centeredness, recovery orientation, trauma, psychosocial rehabilitation, crisis intervention and related tools and skills such as Individual recovery plans, WRAP, self-care, emotional validation, communication skills, boundaries, emotional regulation, relapse prevention, violence prevention and suicide
- Assisting the family in understanding various requirements of the waiver process, such as the individual recovery plan, crisis/safety plan and plan of care process; training on

understanding the individual's diagnoses; understanding service options offered by service providers; and assisting with understanding policies, procedures and regulations that impact the individual with substance use disorder/mental illness concerns while living in the community (e.g., training on system navigation and Medicaid interaction with other individual-serving systems)

- Training on community integration and self-advocacy
- Training on behavioral intervention strategies (e.g., communication skills, relapse prevention, violence and suicide prevention, etc.)
- Training on mental health conditions, services and supports including providing benefits and entitlements counseling and providing skills and knowledge to parents with mental illness and SUD on issues such as problems with Criminal Justice stakeholders, Child Protective Services, Housing entities, etc. Training and technical assistance on caring for medically fragile individuals including those with severe substance use disorder/ mental illness and chronic medical conditions.

Modality

Face-to-face individual and groups.

Setting

Home, Community, office.

Admissions/Eligibility Criteria

- Participant assessed to need, and has a preference for family support and consultation services. All families and those in the individual's support network are eligible for this service at the discretion of the individual
- A release of information from the individual is always required to allow staff to contact significant people, except in cases of threat of injury or death

Limitations/Exclusions

The total combined hours for Family Support and Training are limited to no more than a total of 40 hours in a calendar year.

Certification/Provider Qualifications

Para-professional staff (see appendix) may provide this service.

Staffing Ratio/Case Limits

- 1:15 for staff to individual ratio, and 1:16 for groups with family members.
- Para-professional staff (see appendix) may provide this service.

Mobile Crisis Intervention

Definition

Mobile Crisis Intervention services are provided as part of a comprehensive specialized psychiatric services program available to all Medicaid eligible adults with significant functional impairments meeting the need levels in the 1915(i)-like authority resulting from an identified mental health or co-occurring diagnosis. Mobile Crisis Intervention services are provided to a person who is experiencing or is at imminent risk of having a psychiatric crisis and are designed to interrupt and/or ameliorate a crisis including a preliminary assessment, immediate crisis resolution and de-escalation. Services will be geared towards preventing the occurrence of similar events in the future and keeping the person as connected as possible with environment/activities. The goals of Mobile Crisis Intervention services are engagement, symptom reduction, and stabilization. All activities must occur within the context of a potential or actual psychiatric crisis.

Service Components

Mobile Crisis Intervention services include the following components:

- A preliminary assessment of risk, mental status, medical stability and community tenure and the need for further evaluation or other mental health services. Includes contact with the consumer, family members, and/or other collateral sources (e.g. caregiver, school personnel) with pertinent information for the purpose of a preliminary assessment, treatment and/or referral to other alternative mental health services at an appropriate level
- Crisis resolution and consultation with the identified Medicaid eligible individual and the treatment provider
- Referral and linkage to appropriate Medicaid behavioral health community services to avoid more restrictive levels of treatment
- Linkage to Short Term Crisis Respite or Intensive Crisis Respite when clinically appropriate
- Includes contact with the client, family members, or other collateral sources Short-term CIs include crisis resolution and de-briefing with the identified Medicaid eligible individual and the treatment provider
- Follow-up with the individual, and when appropriate, with the individuals' caretaker and/or family members
- Follow-up with the individual and the individuals' family/supportive network which could be provided by a Peer Specialist in order to confirm linkage to Care Coordination, outpatient treatment or other services as appropriate
- Consultation with a physician or other qualified providers to assist with the individual's specific crisis and plans for the individual's future.

Modality

Mobile Crisis is a face-to-face intervention.

Setting

Mobile Crisis may occur in various settings, including emergency rooms and community locations where a person lives, works, attends school and/or socializes.

Admissions/Eligibility Criteria

All Medicaid eligible adults with significant functional impairments meeting the need levels in the 1915(i)-like authority resulting from an identified mental health or co-occurring diagnosis receiving this service are experiencing or at imminent risk of experiencing a psychiatric crisis.

Limitations/Exclusions

No Limits.

Certification/Provider Qualifications

- Agency must possess a current license to provide crisis and/or treatment services (i.e. clinic, Comprehensive Psychiatric Emergency Programs (CPEP), Partial Hospital, PROS or have licensed professionals who have a minimum of 1 year of experience in delivering off-site crisis services including conducting psychiatric evaluations and providing treatment.
- Agency must demonstrate capacity for mobile crisis visits to be conducted by a minimum of 2 staff persons – one of whom must be a licensed clinician.
- Services must be staffed by a multidisciplinary team including licensed, para-professional and certified peer staff (see appendix).

Staffing Ratio/Case Limits

N/A

Short-term Crisis Respite

Definition

Short-term Crisis Respite is a short-term care and intervention strategy for individuals who have a mental health or co-occurring diagnosis and are experiencing challenges in daily life that create risk for an escalation of symptoms that cannot be managed in the person's home and community environment without onsite supports including:

- A mental health or co-occurring diagnosis and are experiencing challenges in daily life that create imminent risk for an escalation of symptoms and/or a loss of adult role functioning but who do not pose an imminent risk to the safety of themselves or others
- A challenging emotional crisis occurs which the individual is unable to manage without intensive assistance and support
- When there is an indication that a person's symptoms are beginning to escalate

Referrals to Crisis Respite may come from the emergency room, the community, self-referrals, a treatment team, or as part of a step-down plan from an inpatient setting. Crisis respite is provided in site-based residential settings. Crisis Respite is not intended as a substitute for permanent housing arrangements.

Service Components

Components offered may include: peer support, either on site or as a wrap-around service during the respite stay, health and wellness coaching, WRAP planning, wellness activities, family support, conflict resolution, and other services as needed:

- Onsite peer support during the respite stay
- Working with existing treatment providers
- Health and wellness coaching
- Relaxation techniques to help reduce stress, anxiety, emerging panic or feelings of losing control
- Coordinating with primary care, Health Home or other BH providers (on-site or through referrals)
- WRAP (Wellness Recovery Action Plan) planning
- Wellness activities
- Family support
- Conflict resolution
- Ongoing communication between the consumer, crisis respite staff, natural supports, and the individuals' established mental health providers to assure collaboration and continuity in managing the crisis situation and identifying subsequent support and service systems
- Collaboration with the individual, BH providers, and natural supports to make recommendations for modifications to the recipients' plan of care and treatment.

At the conclusion of a Crisis Respite period, crisis respite staff, together with the individual and his or her established mental health providers, will make a determination as to the continuation of necessary care and make recommendations for modifications to the recipients' plan of care.

Modality

Short-term Crisis Respite is a face-to-face service.

Setting

- Site-based residential settings will offer a supportive home-like environment with a maximum preferred capacity of 8-10 guests (fewer in rural areas), preferably in single rooms.
- The setting must be code compliant.
- Staffed and open 24 hours a day, seven days a week when a resident is present.
- Residents should be allowed to leave and return as needed, maintaining employment and other daily activities to the extent possible.

To the greatest extent possible, guests will be encouraged to maintain contact with significant others, including family members, friends, and spouses. To facilitate this contact, guests may have visitors at any time that is convenient and practical for the guest as well as the operations of the CRC.

Admissions/Eligibility Criteria

All individuals receiving this service must be experiencing a crisis, and be:

- Willing to voluntarily stay at a Crisis Respite
- Willing to be assessed by a treating professional including undergo a HARP and 1915(i) assessment
- Willing to authorize release of medical records by relevant treating providers
- Have a mental health or co-occurring diagnosis and are experiencing challenges in daily life that create imminent risk for an escalation of symptoms and/or a loss of adult role functioning but who do not pose an imminent risk to the safety of themselves or others

EXCLUSIONS:

- Diagnosis of dementia, organic brain disorder or TBI
- Those with an acute medical condition requiring higher level of care
- At imminent risk to self or others that requires higher level of care
- Displays symptoms indicative of active engagement in substance use manifested in a physical dependence or results in aggressive or destructive behavior
- Does not have permanent housing or is homeless
- Is not willing or able to respect and follow the guest agreement during his/her stay
- Is not willing to sign necessary registration documentation
- Is not willing to participate in the wellness process during his/her stay

Limitations/Exclusions

No longer than 1 week per episode, not to exceed a maximum of 21 days per year. Individual stays of greater than 72 hours require prior authorization. Individuals requiring crisis respite for longer periods may be evaluated on an individual basis and approved for greater length of stay based on medical necessity.

Certification/Provider Qualifications

Crisis Respite services may be delivered by peers or non-licensed staff (see appendix):

- The CR should have a Program Director (1 FTE) who will have 3-5 years of management experience working in a social service or related setting and will supervise CR staff and coordinate the day-to-day activities associated with managing the CR
- Peer Respite staff will have experience as a recipient of mental health services with a willingness to share personal, practical experience, knowledge, and first-hand insight to benefit program enrollees
- Peer Respite staff will possess the competency to meet requirements outlined in the job description, and will complete any relevant trainings within 90 days of employment

All Peer staff must be OMH or OASAS certified.

Staffing Ratio/Case Limits

- There shall be a minimum of one staff person on-site for every four guests from 7 am to 8 pm.
- Between the hours of 8 pm and 7 am, there shall be a minimum of two staff on-site.
- The director or a designee shall be available at all times by cell phone.

Intensive Crisis Respite

Definition

Intensive Crisis Respite (ICR) is a short-term, residential care and clinical intervention strategy for individuals who are facing a behavioral health crisis, including individuals who are suicidal, express homicidal ideation, or have a mental health or co-occurring diagnosis and are experiencing acute escalation of mental health symptoms. In addition, the person must be able to contract for safety.

Individuals in need of ICR are at imminent risk for loss of functional abilities, and may raise safety concerns for themselves and others without this level of care. The immediate goal of ICR is to provide supports to help the individual stabilize and return to previous level of functioning or as a step-down from inpatient hospitalization.

Service Components

Services offered include:

- Comprehensive assessment including screening for physical health conditions
- Comprehensive risk assessment medication management
- Individual and group counseling
- Training in de-escalation strategies
- Relaxation techniques to help reduce stress, anxiety, panic or feelings of losing control
- Monitoring for high risk behavior
- Psychiatric evaluation for competency
- Linkage to resources and referrals to community-based mental health and substance abuse treatment
- Peer support
- WRAP (Wellness Recovery Action Plan) planning
- Wellness activities
- Family support
- Engagement of Natural Supports
- Conflict resolution
- Hotline

Ongoing communication between individuals receiving ICR, crisis respite staff, and the individuals' established mental health providers is necessary to assure collaboration and continuity in managing the crisis, as well as to identify effective subsequent support and service resources. At the conclusion of an Intensive Crisis Respite period, clinical staff, together with the individual, will make recommendations for modifications to the recipients' plan of care.

Modality

Intensive Crisis Respite is a face-to-face intervention.

Setting

Participants are encouraged to receive respite in the most integrated and cost-effective settings appropriate to meet their respite needs, preferably in a residential, community-based setting.

Admissions/Eligibility Criteria

- Individuals who may be a danger to self or others and are experiencing acute escalation of mental health symptoms and/or at imminent risk for loss of functional abilities, and raise safety concerns for themselves and others but can contract for safety.
- Experiencing symptoms beyond what can be managed in a short term crisis respite.
- Individual does not require inpatient admission or can be used as an alternative to inpatient admission if clinically indicated and person can contract for safety.

Limitations/Exclusions

- 7 days maximum
- Intensive Crisis Respite services include a limit of 21 days per year. Individuals requiring Intensive Crisis Respite for longer periods than those specified may be evaluated on an individual basis and approved for greater length of stay based on medical necessity.
- Have an acute medical condition requiring higher level of care.

Certification/Provider Qualifications

- Agency must possess a current license to provide crisis and/or treatment services (i.e. clinic, Comprehensive Psychiatric Emergency Programs (CPEP), Partial Hospital, PROS, Psychiatric Inpatient or have licensed professionals who have a minimum of 1 year of experience in delivering off-site crisis services including conducting psychiatric evaluations and providing treatment.
- Agency must demonstrate capacity for mobile crisis visits to be conducted by a minimum of 2 staff persons – one of whom must be a licensed clinician.
- This service will be provided by a multidisciplinary team of licensed, para-professional and certified peer staff.

Staffing Ratio/Case Limits

- Adequate number of staff and an appropriate staff composition to carry out its goals and objectives as well as to ensure the continuous provision of sufficient ongoing and emergency supervision and treatment.
- Every ICR shall have at least one psychiatrist as primary medical coverage. Back-up coverage may be a physician who will consult with the psychiatrist. The psychiatrist or physician shall be on call 24-hours-a-day and will make daily rounds. Counties of less than 50,000 population may utilize a licensed physician for on-call activities and daily rounds as long as the physician has postgraduate training and experience in diagnosis and treatment of SMI and SUD
- At least one registered nurse shall be on duty 24-hours-a-day, 7-days-a-week when there is a consumer in care.
- Staffing ratio:

Beds:	1-10	11-20
RNs	1	1
Mental Health Treatment Staff	1	2

Education Support Services

Definition

Education Support Services are provided to assist individuals with mental health or substance use disorders who want to start or return to school or formal training with a goal of achieving skills necessary to obtain employment. Education Support Services consist of special education and related services as defined in Sections (22) and (25) of the Individuals with Disabilities Education Improvement Act of 2004 (IDEA) (20 U.S.C. 1401 et seq.), to the extent to which they are not available under a program funded by IDEA or available for funding by the NYS Adult Career & Continuing Education Services Office of Vocational Rehabilitation (ACCES-VR) (The Vocational Rehabilitation component (ACCES-VR) encompasses many of the services that were previously part of Vocational and Educational Services for Individuals with Disabilities, or VESID).

Education Support Services may consist of general adult educational services such as applying for and attending community college, university or other college-level courses. Services may also include classes, vocational training, and tutoring to receive a Test Assessing Secondary Completion (TASC) diploma, as well as support to the participant to participate in an apprenticeship program.

Participants authorized for Education Support Services must relate to an employment goal or skill development documented in the service plan. Education Support Services must be specified in the service plan as necessary to enable the participant to integrate more fully into the community and to ensure the health, welfare and safety of the participant. Examples of these goals would include, but not be limited to: tutoring or formal classes to obtain a Test Assessing Secondary Completion (TASC) diploma, vocational training, apprenticeship program or formal classes to improve skills or knowledge in a chosen career, community college, university or any college-level courses or classes.

Ongoing Supported Education: is conducted after a participant is successfully admitted to an educational program. Ongoing follow-along is support available for an indefinite period as needed by the participant to maintain their status as a registered student.

Service Components

Service components include:

- Providing support in a variety of educational settings, such as classroom and test-taking environments
- Serve as a resource clearinghouse for educational opportunities, tutoring, financial aid and other relevant educational supports and resources
- Provide linkages to education-related community resources including supports for learning and cognitive disabilities
- Assist with admission applications and registration
- Identify financial aid resources and assist with applications
- Assist with transitions and/or withdrawals from programs such as those resulting from mental health or substance abuse challenges, issues and medical conditions and other co-occurring disorders
- Orient individual to school settings, navigating the school system and student services particularly disability services
- Providing cognitive remediation services to improve executive functioning abilities such as attention, organizing, planning and working memory
- Conducting a needs assessment, based on employment goal to identify education/training requirements, personal strengths and necessary support services
- Evaluate educational/ career plan on an ongoing basis and revise as needed in response to

individuals' needs and recovery process

- Assist with skill development including study skills, note taking, time and stress management and social skills in relation to mental health and SUD history and other related issues
- Providing advocacy support to obtain accommodations such as requesting extensions for assignments and different test-taking setting if needed for documented cognitive or learning disability
- Providing instruction on self-advocacy skills in relation to independent functioning in the educational environment

Modality

Face to face service.

Setting

Ideal setting is in the educational setting site, but can also be provided at program site and other community-based locations as well as the individual's home.

Admissions/Eligibility Criteria

Individual who have been assessed to need Education Support Services and clearly stated interest in obtaining employment with the skills obtained.

Limitations/Exclusions

- The hours for supported education are limited to no more than a total of 250 hours per year. Documentation is maintained in the file of each individual receiving this service that the service is not otherwise available under section 110 of the Rehabilitation Act of 1973 or the IDEA.
- Can only access this service if other appropriate state plan services are not available or appropriate.

Certification/Provider Qualifications

- Education Specialists should possess a BA, and two years of experience supporting individuals in pursuing education goals.
- A supervisor may be non-licensed (see appendix) and requires a minimum of a BA (preferably a Masters in Rehabilitation or a relevant field), a minimum of three years of relevant work experience preferably as an education specialist. All staff should have minimum of two years working in the behavioral health.
- Staff should have knowledge in the following areas: disability accommodations and assistive technology, financial aid, student loan default, SUD recovery resources on campus, etc.

Staffing Ratio/Case Limits

- Maximum caseload for a full-time education specialist is 20 individuals and proportional number for part-time staff.

Empowerment Services - Peer Supports

Definition

Peer Support services are peer-delivered services with a rehabilitation and recovery focus. They are designed to promote skills for coping with and managing behavioral health symptoms while facilitating the utilization of natural resources and the enhancement of recovery-oriented principles (e.g. hope and self-efficacy, and community living skills). Peer support uses trauma-informed, non-clinical assistance to achieve long-term recovery from SUD and Mental health issues.

Activities included must be intended to achieve the identified goals or objectives as set forth in the participants individualized recovery plan, which delineates specific goals that are flexibly tailored to the participant and attempt to utilize community and natural supports. The intent of these activities is to assist recipients in initiating recovery, maintaining recovery, sustaining recovery and enhancing the quality of personal and family life in long-term recovery.

The structured, scheduled activities provided by this service emphasize the opportunity for peers to support each other in the restoration and expansion of the skills and strategies necessary to move forward in recovery. Persons providing these services will do so through the paradigm of the shared personal experience of recovery.

Service Components

There are 6 categories of peer-support components. They include:

1. Advocacy:

- Assistance seeking and obtaining benefits and entitlements, food, shelter, permanent housing
- Assisting recipients in participating in shared decision making (e.g. MyPSYCKES)
- Linkage to and systems navigation within behavioral health and allied human services systems to access appropriate care (e.g. Peer Bridgers)
- Benefits advisement and planning
- Development of psychiatric advance directives (PAD)
- Assistance advocating for self-directed services

2. Outreach and Engagement:

- Companionship and modeling of recovery lifestyle, including participation in recovery activities that might be beyond the scope of treatment providers (e.g., eating together at a restaurant, attending or participating in a sporting event, attending a social event such as a concert or recovery celebration event)
- Raising the awareness of existing services, pathways to recovery and helping a person to remove barriers that exist for access to them
- Interim visits with individuals after discharge from Hospital Emergency Rooms, Detox Units or Inpatient Psychiatric Units to facilitate community tenure and increased readiness while waiting for the first post-discharge visit with a community-based mental health provider, treatment provider or appropriate system of care

3. Self-help tools:

- Assist selecting and utilizing self-directed recovery tools such as Wellness Recovery Action Plan (WRAP) or Individualized Recovery Plan
- Assist selecting and utilizing the things that bring a sense of passion, purpose and meaning into his/her life and coaching the person as they identify barriers to engaging in these activities
- Assist individuals to help connect to natural supports that enhance the quality and security of life

- Connecting individuals to “warm lines”
- Connections to self-help groups in the community

4. Recovery Supports:

- Recovery education and coaching for individuals and their family members.
- One to one peer support
- Person centered goal planning that incorporates life areas such as community connectedness, physical wellness, spirituality, employment, self-help
- Assisting with skills development that guides people towards a more independent life

5. Transitional Supports:

- Bridging from Jail or prison to a person’s home (note: that peer supports while in Jail are not Medicaid reimbursable)
- Bridging from institutions to a person’s home (note: that peer supports while in an institution are not Medicaid reimbursable)
- Bridging from general hospitals to a person’s home
- Bridging from a person’s home to the community

6. Pre-crisis and Crisis Supports:

- Providing companionship when a person is in an emergency room or crisis unit or preparing to be admitted to detox, residential or other service to deal with crisis
- Providing peer support in the person’s home or in the community to support them before (or in) a crisis or relapse
- Developing crisis diversion plans or relapse prevention plans

Modality

This is a face to face service.

Setting

Peer supports may be provided in a variety of setting including: inpatient, outpatient, community, and respite programs. With the exception of services provided in inpatient settings the majority of the contacts with the recipient should be offsite in the community. Meeting at community locations such as may include: a person’s home, homeless shelters and soup kitchens for the purpose of opening up a dialogue. Note: Peer Support must be the individual’s recovery plan.

Admissions/Eligibility Criteria

Peer support is voluntary, subject to periodic review of goals and based on medical necessity.

Limitations/Exclusions

Peer support services are limited to no more than a total of 500 hours in a calendar year. Individuals receiving SUD outpatient treatment may not receive Peer Supports, if they are receiving an OASAS state plan peer service.

Note: peer services while an individual is incarcerated or institutionalized are not Medicaid reimbursable. Time spent on the phone with individuals is not Medicaid reimbursable. The cost of admission to an event (i.e., sports event or concert) is not Medicaid reimbursable. Advocacy for community improvement (not specific to the Medicaid eligible individual) is not Medicaid reimbursable.

Certification/Provider Qualifications

Peer support providers must have a certification as of the following:

- OMH established Certified Peer Specialist
- OASAS established Peer Specialist

Certified Peer Specialists are appropriately supervised treatment team members who will play an integral role in care planning including the Wellness Recovery Action Plan (WRAP), treatment planning and the development of psychiatric advance directives (PAD). Training for Peer Specialists will be provided/contracted by OMH and OASAS and will focus on the principles and concepts of recovery, coping skills, and advocacy, the unique competencies needed to assist another individual based on the shared personal experience paradigm.

Supervision of peer support must be provided by a licensed behavioral health practitioner.

Staffing Ratio/Case Limits

Maximum 1 FTE to 20 consumers.

Non-Medical Transportation

Definition

Non-medical Transportation services are offered, in addition to any medical transportation furnished under the 42 CFR 440.17(a) in the State Plan. Non-medical Transportation services are necessary, as specified by the service plan, to enable participants to gain access to authorized home and community based services that enable them to integrate more fully into the community and ensure the health, welfare, and safety of the participant.

This service will be provided to meet the participant's needs as determined by an assessment performed in accordance with Department requirements and as outlined in the participant's service plan.

Service Components

Transportation services consist of:

Transportation (per/mile) - This Transportation service is delivered by providers, family members, and other qualified, licensed drivers. Mileage is used to reimburse the owner of the vehicle or other qualified, licensed driver who transports the participant to and from services and resources related to outcomes specified in the participant's service plan. The unit of service is one mile. Mileage can be paid round trip. A round trip is defined as from the point of first pickup to the service destination and the return distance to the point of origin.

When Transportation is provided to more than one participant at a time, the provider will divide the shared miles equitably among the participants to whom Transportation is provided. The provider is required (or it is the legal employer's responsibility under the Vendor Fiscal/Employer Agent (FMS) model) to track mileage, allocate a portion to each participant, and provide that information to the Case Manager for inclusion in the participant's service plan.

Services must be delivered in a manner that supports the participant's communication needs including, but not limited to, age appropriate communication, translation services for participants that are of limited-English proficiency or who have other communication needs requiring translation, assistance with the provider's understanding and use of communication devices used by the participant.

Public Transportation - The utilization of Public Transportation promotes self-determination and is made available to participants as a cost-effective means of accessing services and activities. This service provides payment for the individual's use of public transportation.

The Care Manager will monitor this service quarterly and will provide ongoing assistance to the participant to identify alternative community-based sources of transportation.

Replacement cards for lost or stolen cards or passes are to be approved by Case Manager. Participants must report lost or stolen card/pass and have written documentation to present.

Modality

In person

Setting

Community

Admissions/Eligibility Criteria

The type and amount of waiver transportation must be included in the approved Service Plan.

Limitations/Exclusions

No more than \$2,000 per calendar year for both public and mile reimbursement combined.

Non-Medical Transportation will only be available for non-routine, time-limited services, not for ongoing treatment or services.

All other options for transportation, such as informal supports, community services, and public transportation must be explored and utilized prior to requesting waiver transportation. This service is not intended to replace services provided by ACCES-VR, or any other existing provider, but compliment them.

Individuals enrolled in residential services who receive transportation as part of the benefit will not be eligible for this 1915(i)-like service.

Certification/Provider Qualifications

A provider of transportation may be an agency or provider contracted by the managed care company for the provision of non-medical transportation, a public/mass transportation service, or a family member or individual designated in the Service Plan. All providers must have a current New York State driver's license in good standing; drive a New York State-registered, inspected and insured vehicle; and be identified in the Service Plan. For contracting provider agencies, drivers must have a clean driving record with no history of DWI/DUI in the preceding 5 years.

Staffing Ratio/Case Limits

The unit of service is one mile. Mileage can be paid round trip. A round trip is defined as from the point of first pickup to the service destination and the return distance to the point of origin. When Transportation is provided to more than one participant at a time, the provider will divide the shared miles equitably among the participants to whom Transportation is provided. The provider is required to track mileage, allocate a portion to each participant, and provide that information to the Case Manager for inclusion in the participant's service plan.

Pre-vocational Services

Definition

Pre-vocational services are time-limited services that prepare a participant for paid or unpaid employment. This service specifically provides learning and work experiences where the individual with mental health and/or disabling substance use disorders can develop general, non-job-task-specific strengths and soft skills that contribute to employability in competitive work environment as well as in the integrated community settings. Pre-vocational services occur over a defined period of time and with specific person centered goals to be developed and achieved, as determined by the individual and his/her employment specialist and support team and ongoing person-centered planning process as identified in the individual's person-centered plan of care. Pre-vocational services provide supports to individuals who need ongoing support to learn a new job and/or maintain a job in a competitive work environment or a self-employment arrangement. The outcome of this pre-vocational activity is documentation of the participant's stated career objective and a career plan used to guide individual employment support.

Service Components

Service components include:

- Teaching concepts such as: work compliance, attendance, task completion, problem solving, and safety, and, if applicable, teach individuals how to identify obstacles to employment, obtain paperwork necessary for employment applications, and how to interact without the use of drugs with people who have not used drugs especially in the work place
- Providing scheduled activities outside of an individual's home that support acquisition, retention, or improvement in job-related skills related to self-care, sensory-motor development, socialization, daily living skills, communication community living, social and cognitive skills. This could include opening and maintaining a bank account for work-related direct deposit
- Gaining work-related experience considered crucial for job placement (e.g., volunteer work, time-limited unpaid internship) and career development

Services do not include development of job specific skills.

Modality

Pre-vocational services are face-to-face services.

Setting

This service is generally provided at the program site, but also includes support at a work location where the individual may acquire work-related experience such as volunteering and internships in the community.

Admissions/Eligibility Criteria

Individual must have a clear desire to work in competitive employment.

Limitations/Exclusions

The total combined hours (for pre-vocational services and transitional supported employment) are limited to no more than a total of 250 hours and a duration of 9 months of service in a calendar year.

For all employment supports services, documentation is maintained in the file of each individual receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.). Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses, such as the following:

- Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program
- Payments that are passed through to users of supported employment programs
- Payments for training that is not directly related to an individual's supported employment program

When Pre-vocational services are provided at a work site where persons without disabilities are employed, payment is made only for the adaptations, supervision, and training required by participants receiving waiver services as a result of their disabilities but does not include payment for the supervisory activities rendered as a normal part of the business setting or work environment.

Certification/Provider Qualifications

- Employment Specialists may be non-licensed (see appendix) and should possess education and experience equivalent to an undergraduate degree in vocational services, disabilities services, business, personnel management, mental health or social services counseling.
- A program manager requires a minimum of a BA (preferably a Masters in Rehabilitation or a behavioral health field) and a minimum of three years' relevant work experience preferably as an employment specialist and minimum 18 months of management experience in a SUD rehab/treatment setting.
- OASAS Certified Clinics and in community based programs.

Staffing Ratio/Case Limits

- Maximum caseload for a full-time employment specialist is 20 clients and respective proportions for part-time staff.
- The recommended program manager to staff ratio is 1:10.

Transitional Employment

Definition

This service is designed to strengthen the participant's work record and work skills toward the goal of achieving assisted or unassisted competitive employment at or above the minimum wage paid by the competitive sector employer. This service is provided, instead of individual supported employment, only when the person specifically chooses this service and may only be provided by clubhouse, psychosocial club program certified provider or recovery center

This service specifically provides learning and work experiences where the individual with behavioral health and/or substance use disorders can develop general, non-job-task-specific strengths and soft skills that contribute to employability in the competitive work environment in integrated community settings paying at or above minimum wage.

The outcome of this activity is documentation of the participant's stated career objective and a career plan used to guide individual employment support.

Service Components

Service components include:

- Provide time-limited employment and on-the-job training in one or more integrated employment settings as an integral part of the individual's vocational rehabilitation growth.
 - Provide support to participants to gain skills to enable transition to integrated, competitive employment
 - Training activities provided in regular business, industry, and community settings
 - Promoting integration into the workplace and interaction between people without disabilities in those workplaces and other program participants if the TE placement is made for a group as well as individuals in recovery as well as those without disabling addiction or substance use disorders
 - Provide Transitional Employment supports during placement. This support includes: initial and ongoing employment planning and advancement, employment assessment not otherwise covered in the annual career planning, job placement, job development, negotiation with prospective employers, job analysis, training and systematic instruction, job coaching, benefits supports, training, and planning transportation
 - Training or referral to a training program
 - Planning transportation
 - Encourage and instill self-confidence to work in competitive employment
 - ADL skills specific to the TE placement
 - Teach Activities of Daily Living (ADL) skills specific to the Transitional Employment placement and may include appropriate dress, hygiene, walk, talk, and eye contact, money management, dealing with outstanding warrants, and legal history, time management, collection of work related documentation and credentials
 - Offer Services not specifically related to job skill training that enable the waiver participant to be successful in integrating into the job setting
-
- Providing on the job supports, including:
 - On-site job training
 - Assisting the participant to develop natural supports in the workplace without the use of substances

- Adopt an identity as a worker
- Accept responsibility for decision
- Examine past work experiences for failure and successes.
- Consider potential for transferability of skills
- Coordinate with employers and coworkers, as necessary, to accommodate the individual in meeting employment expectations, and addressing work related and personal issues as they arise

Modality

Transitional Employment is a face-to-face intervention.

Setting

Clubhouses for OMH populations only, OASAS Certified Clinics and in community based programs.

Admissions/Eligibility Criteria

- An individual must have made a clear decision to work in competitive employment in the community regardless of limited or unsuccessful work history, or present status of sobriety and/or abstinence.
- The basic tenet of Transitional Employment is that all individuals are capable of working in competitive employment in the community even without prior training and all individuals interested in employment should be given the opportunity.

Limitations/Exclusions

The total combined hours for pre-vocational and transitional supported employment) are limited to no more than a total of 250 hours and a duration of 9 months of service in a calendar year.

Additionally, Transitional Employment placements should be part-time and time-limited, usually 15-20 hrs/week from 6-9 months in duration.

For all employment supports services, documentation is maintained in the file of each individual receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.). Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses, such as the following: incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program, payments that are passed through to users of the state VR supported employment programs, and payments for training that is not directly related to an individual's supported employment program. When employment support services are provided at a work site where persons without disabilities are employed, payment is made only for the adaptations, supervision, and training required by participants receiving waiver services as a result of their disabilities but does not include payment for the supervisory activities rendered as a normal part of the business setting.

Certification/Provider Qualifications

- Employment Specialists may be non-licensed (see appendix) and should possess education and experience equivalent to an undergraduate degree in vocational services, business, personnel management, disability, mental health or social services.
- A program manager requires a minimum of a BA (preferably a Masters in Rehabilitation or a behavioral health field) and a minimum of three years' relevant work experience working in a rehab or SUD treatment setting and minimum 18 months of management experience.
- Additionally, Clubhouses/Psychosocial clubs and Recovery Centers may be certified by

Clubhouse International, certified/licensed as Recovery Centers, or at a minimum provide services similar to those of clubhouses.

Staffing Ratio/Case Limits

- Maximum caseload for a full-time employment specialist is 20 clients and respective proportions for part-time staff.
- The recommended program manager to staff ratio is 1:10.

Intensive Supported Employment (ISE)

Definition

ISE services that assist individuals with MH/SUD to obtain and keep competitive employment. These services consist of intensive supports that enable individuals to obtain and keep competitive employment at or above the minimum wage. This service will follow the evidence based principles of the Individual Placement and Support (IPS) model.

This service is based on Individual Placement Support (IPS) model which is an evidence based practice of supported employment. It consists of intensive supports that enable individuals for whom competitive employment at or above the minimum wage is unlikely, absent the provision of supports, and who, because of their clinical and functional needs, require supports to perform in a regular work setting. Individual employment support services are individualized, person-centered services providing supports to participants who need ongoing support to learn a new job and maintain a job in a competitive employment or self-employment arrangement. Participants in a competitive employment arrangement receiving Individual Employment Support Services are compensated at or above the minimum wage and receive not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. The outcome of this activity is documentation of the participant's stated career objective and a career plan used to guide individual employment support. Services that consist of intensive supports that enable participants for whom competitive employment at or above the minimum wage is unlikely, absent the provision of supports, and who, because of their disabilities, need supports to perform in a regular work setting.

Service Components

Components include:

- Assist the participant to locate a job or develop a job on behalf of the individual via the use of individualized placement and support services that include rapid job search including acquisition of hard and soft skills to retain employment, training and systematic instruction, as well as providing support for the job application process such as resume writing, interviewing and application submission
- Support the individual to establish or maintain self-employment, including home-based self-employment
- Provide ongoing job related discovery and assessment

Provide job placement, systematic job development, job coaching, negotiation with prospective employers, job analysis, job carving (creating, modifying, or customizing a community-based job such that it can be successfully performed by an individual on supported employment,) customize employment training and systematic instruction, benefits counseling support, training and planning, transportation, asset development and career advancement services, customized employment, and other workforce support services. Workforce support services include benefits counseling support (e.g., personalized benefits counseling that assists individuals in obtaining personalized information about their government entitlements), training and planning, transportation navigation, asset development and career advancement services.

Modality

Intensive Supported Employment is a face-to-face intervention.

Setting

This service is generally provided at an employment program but can be provided at a location of the participant's choosing including the workplace based on individual need.

Admissions/Eligibility Criteria

- In order to achieve a successful outcome in ISE, an individual must have made a clear decision to work in competitive employment in the community.
- The basic tenet of ISE is that all individuals are capable of working in competitive employment in the community even without prior training and all individuals interested in employment should be given the opportunity.
- The ongoing level of care criteria including service duration, intensity and effectiveness should be reviewed by the HCBS care manager and/or the MCO at least quarterly.

Limitations/Exclusions

250 hours per calendar year.

For all employment supports services, documentation is maintained in the file of each individual receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.). Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses, such as the following: incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program, payments that are passed through to users of supported employment programs, and payments for training that is not directly related to an individual's supported employment program. When employment support services are provided at a work site where persons without disabilities are employed, payment is made only for the adaptations, supervision, and training required by participants receiving waiver services as a result of their disabilities but does not include payment for the supervisory activities rendered as a normal part of the business setting.

Certification/Provider Qualifications

- Employment Specialists may be non-licensed (see appendix) and should possess education and experience equivalent to an undergraduate degree in vocational services, business, personnel management, disability, mental health or social services.
- A program manager requires a minimum of a BA (preferably a Masters in a behavioral health field or vocational rehabilitation) and a minimum of three years' relevant work experience preferably as an employment specialist or in a SUD treatment setting; and minimum 18 months of management experience.

Staffing Ratio/Case Limits

- Maximum caseload for a full-time employment specialist is 20 clients and respective proportions for part-time staff.
- The recommended program manager to staff ratio is 1:10.

Ongoing Supported Employment

Definition

This service is provided after a participant successfully obtains and becomes oriented to competitive and integrated employment. Ongoing follow-along is support available for an indefinite period as needed by the participant to maintain their paid employment position. Individual employment support services are individualized, person centered services providing supports to participants who need ongoing support to learn a new job and maintain a job in a competitive employment or self-employment arrangement. Participants in a competitive employment arrangement receiving Individual Employment Support Services are compensated at or above the minimum wage and receive not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. The outcome of this activity is documentation of the participant's stated career objective and a career plan used to guide individual employment support.

Service Components

Service components include:

- Providing support in a variety of settings, particularly work sites where persons without disabilities are employed:
 - Assists individuals to identify reasonable accommodations necessary to manage mental health symptoms that may emerge at work
 - Provides activities needed to retain paid work including job coaching and non-work task related training
 - Ongoing Supported Employment services may include assessment of issues and linkage/referral to other community resources as appropriate
- Providing activities needed to sustain paid work by participants, including supervision and training:
 - Provides supports to individuals who are currently employed in settings that are competitive and integrated
 - Assists individuals to establish positive workplace relationships, including interactions with supervisors, and co-workers
 - Helps individuals to build and sustain skills in the workplace, including time management, co-worker relationships, understanding supervisory roles and expectations, and accessing workplace supports, including EAP and job training
- Providing reminders of effective workplace practices and reinforcement of skills gained during the period of intensive supported employment services:
 - Assist individuals to manage mental health issues that may impact their ability to sustain employment

The basic tenet of ISE is that all individuals are capable of working in competitive employment in the community even without prior training and all individuals interested in employment should be given the opportunity.

Modality

Ongoing Supported Employment is a face-to-face intervention.

Setting

Ongoing Supported Employment services may be provided in any community location as well as at the workplace. Its primary focus is to support individuals to manage MH/SUD issues in a manner that will not jeopardize their employment.

Focus and delivery on Ongoing Supported Employment may not duplicate vocational services for

which the person is eligible through Rehabilitation Services Act (RSA/ACCES-VR).

Admissions/Eligibility Criteria

Must have made a clear goal to work in competitive employment in the community.

Limitations/Exclusions

250 hours per calendar year.

For all employment supports services, documentation is maintained in the file of each individual receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.). Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses, such as the following: incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program, payments that are passed through to users of supported employment programs, and payments for training that is not directly related to an individual's supported employment program. When employment support services are provided at a work site where persons without disabilities are employed, payment is made only for the adaptations, supervision, and training required by participants receiving waiver services as a result of their disabilities but does not include payment for the supervisory activities rendered as a normal part of the business setting.

Certification/Provider Qualifications

- Employment Specialists may be non-licensed (see appendix) and should possess education and experience equivalent to an undergraduate degree in vocational services, business, personnel management, disability, mental health or social services.
- A program manager requires a minimum of a BA (preferably a Masters in a behavioral health field or vocational rehabilitation) and a minimum of three years' relevant work experience preferably as an employment specialist or in a SUD treatment setting; and minimum 18 months of management experience.

Staffing Ratio/Case Limits

- Maximum caseload for a full-time employment specialist is 20 clients and respective proportions for part-time staff.
- The recommended program manager to staff ratio is 1:10.

VI. Appendix

HCBS Service Clusters:

Many of the 1915i-like services are designed to be provided in clusters that promote recovery along a spectrum. The clusters include:

- Community Psychiatric Support and Treatment (CPST) and Psychosocial Rehabilitation (PSR)
- Crisis Services- Mobile Crisis Intervention, Intensive Crisis Respite and Short-term Crisis Respite
- Employment Services- Pre-vocational, Transitional, Intensive Supported Employment, Ongoing Supported Employment
- Peer Supports may be used in conjunction with other HCBS services.

HCBS Provider Competencies in Evidence Based Practices:

Licensed, non-licensed and certified peers who provide HCB services are encouraged to become trained on the various evidence based practices (EBPs). Free modules on various EBPs are available on the Website of Columbia University's Center for Practice Innovation's website (CPI; <http://practiceinnovations.org/>). The New York State Office of Mental Health (OMH) and the Department of Psychiatry, Columbia University, established the Center for Practice Innovations at Columbia Psychiatry and New York State Psychiatric Institute in November, 2007, to promote the widespread use of evidence-based practices throughout New York State. CPI uses innovative approaches to build stakeholder collaborations, develop and maintain practitioners' expertise, build agency infrastructures that support implementing and sustaining evidence-based practices and direct staff competence. CPI is available to collaborate with agencies to increase the use of EBPs and improve staff clinical competencies.

CPI offers the following web-based training modules:

- Treating co-occurring mental health and substance use disorders (called "Focus on Integrated Treatment" or FIT)
- Assertive community treatment (ACT)
- Supported employment/education via individual placement and support (IPS)
- Wellness self-management (WSM)
- First episode psychosis (called OnTrackNY)
- Increasing the use of clozapine
- Suicide prevention
- Tobacco dependence treatment

CPI also offers programs training and other supports to help programs build capacity to implement evidence-based practices. These include:

- Online training modules using personal recovery stories, clinical vignettes, interactive exercises, frequent knowledge checks, and expert panel presentations to engage the learner (over 40 to date. As of January 31, 2014, 14,072 participants have completed 157,164 modules)
- Face-to-face training

- Interactive webinars
- Online resource library with practical tools
- Consultations (both in person and by telephone)

The Northeast Addiction Technology Center has many resources for SUD HCBS providers and can be found at <http://www.nattc.org/home/>.

Staffing Guidelines:

- I. **Professional staff** means practitioners possessing a license or a permit from the New York State Education Department who are qualified by credentials, training, and experience to provide direct services related to the treatment of mental illness and shall include the following:
 - a. ***Certified Rehabilitation Counselor (CRC)*** is certified with a national Certified Rehabilitation Counselor (CRC) designation by The Commission on Rehabilitation Counselor Certification (CRCC) that sets the standard for quality rehabilitation counseling services in the United States and Canada. All VR staff within the OASAS treatment provider system must adhere to the Code of Ethics set forth by the NYS Ethics Commission (<http://www.nyintegrity.org/>) and/ or the Commission on Rehabilitation Counselor Certification (CRCC) (www.crccertification.com)
 - b. ***Creative arts therapist*** is an individual who is currently licensed as a creative arts therapist by the New York State Education Department or possesses a creative arts therapist permit from the New York State Education Department.
 - c. ***Licensed practical nurse*** is an individual who is currently licensed as a licensed practical nurse by the New York State Education Department or possesses a licensed practical nurse permit from the New York State Education Department.
 - d. ***Licensed psychoanalyst*** is an individual who is currently licensed as a psychoanalyst by the New York State Education Department or possesses a permit from the New York State Education Department.
 - e. ***Licensed psychologist*** is an individual who is currently licensed as a psychologist by the New York State Education Department or possesses a permit from the New York State Education Department and who possesses a doctoral degree in psychology, or an individual who has obtained at least a master's degree in psychology who works in a federal, state, county or municipally operated clinic. Such master's degree level psychologists may use the title "psychologist," may be considered professional staff, but may not be assigned supervisory responsibility.
 - f. ***Marriage and family therapist*** is an individual who is currently licensed as a marriage and family therapist by the New York State Education Department or possesses a permit from the New York State Education Department.
 - g. ***Mental health counselor*** is an individual who is currently licensed as a mental health counselor by the New York State Education Department or possesses a permit from the New York State Education Department.

- h. **Nurse practitioner** is an individual who is currently certified as a nurse practitioner by the New York State Education Department or possesses a permit from the New York State Education Department.
- i. **Nurse practitioner in psychiatry** is an individual who is currently certified as a nurse practitioner with an approved specialty area of psychiatry (NPP) by the New York State Education Department or possesses a permit from the New York State Education Department.
- j. **Physician** is an individual who is currently licensed as a physician by the New York State Education Department or possesses a permit from the New York State Education Department.
- k. **Physician assistant** is an individual who is currently registered as a physician assistant by the New York State Education Department or possesses a permit from the New York State Education Department.
- l. **Psychiatrist** is an individual who is currently licensed to practice medicine in New York State, who (i) is a diplomate of the American Board of Psychiatry and Neurology or is eligible to be certified by that Board, or (ii) is certified by the American Osteopathic Board of Neurology and Psychiatry or is eligible to be certified by that Board.
- m. **Registered professional nurse** is an individual who is currently licensed as a registered professional nurse by the New York State Education Department or possesses a permit from the New York State Education Department.
- n. **Social worker** is an individual who is either currently licensed as a licensed master social worker or as a licensed clinical social worker (LCSW) by the New York State Education Department, or possesses a permit from the New York State Education Department to practice and use the title of either licensed master social worker or licensed clinical social worker.

II. Paraprofessional/Non-licensed staff:

- a. **Para-professional:** Individuals 18 years of age or older with a High School diploma or equivalent and 1-3 years of relevant experience or a BA degree.
- b. **Non-licensed staff:** Staff must have a high school diploma or equivalent, and must be 18 years of age and have experience working with individuals with SUD disorders and/or SMI. A Certified Peer Specialist, or equivalently qualified by education in the human services field or a combination of work experience and education, with one year of education substituting for one year of experience. A LMHP or QHP shall be available at all times to provide supervision, back up, support and/or consultation.

Direct service staff should be appropriately licensed or credentialed, trained and experienced practitioners with appropriate skills for engaging family members; providing education about substance use disorder/mental illness and its treatment; possessing information on community resources; guidance on how to manage or cope with substance use disorder relapse, maladaptive behaviors; emotional support and counseling; crisis planning; and problem solving skills training.

III. Certified Peer:

- a. ***OMH-certified Peer Specialist***
- b. ***OASAS-certified Peer Advocate***

IV. State Credentialed Staff

- a. **CASAC:** Staff person who holds a credential by the Office of Alcohol and Substance Abuse as a Credentialed Alcohol and Substance Abuse Counselor
- b. **CASAC-T:** Staff person who holds a credential by the Office of Alcohol and Substance Abuse as a Credentialed Alcohol and Substance Abuse Counselor

V. Other Credentialed Staff

Certified Psychiatric Rehabilitation Practitioner (CPRP): Staff person who holds a credential from the Psychiatric Rehabilitation Association as a practitioner working within the adult mental health system.

HCBS Documentation & Quality Assurance Reviews

HCBS Documentation requirements for encounters:

- Name of consumer
- Type of service provided
- Date of service provided
- Location of service
- Duration of service, including start and end times
- Description of interventions to meet Plan of Care goals
- Outcome (s) or Progress made toward goal achievement
- Follow up/ next steps
- Your name, qualifications, signature and date

Quality Assurance Reviews:

- Quality Assurance reviews and claims audits will be conducted by NYS or its designee, including Local Government Units, to ensure providers comply with the rules, regulations, and standards of the program, and may be conducted without prior notice.
- The Quality Assurance reviews will focus on program aspects, but may include technical requirements such as billing, claims, and other Medicaid program requirements.
- Managed care plans may also be developing protocols to oversee the provision of these services in their provider networks.

ATTESTATION FORM**AGENCY NAME:****AGENCY ADDRESS:****CFR AGENCY CODE:****FEDERAL EMPLOYER ID NUMBER:****Person to Contact with Regard to Questions Concerning this Attestation:**

**(Provider Name) _____ IS SEEKING TO BE
DESIGNATED TO PROVIDE THE FOLLOWING HOME AND COMMUNITY BASED
SERVICES:**

- ☐ Community Psychiatric Support and Treatment (CPST)
- ☐ Psychosocial Rehabilitation (PSR)
- ☐ Residential Support Services
- ☐ Family Support and Training
- ☐ Mobile Crisis Intervention
- ☐ Short-term Crisis Respite
- ☐ Intensive Crisis Respite
- ☐ Pre-vocational Employment
- ☐ Transitional Employment
- ☐ Intensive Supported Employment (ISE)
- ☐ Ongoing Supported Education
- ☐ Education Support Services
- ☐ Peer Supports
- ☐ Non-Medical Transportation

ATTESTATION STATEMENT

I HEREBY ATTEST THAT I AM THE DIRECTOR OF (Name of Provider _____), THAT I AM AUTHORIZED BY (Provider _____) TO EXECUTE THIS ATTESTATION AND THAT I HAVE READ AND UNDERSTAND THE REQUIREMENTS FOR THE ABOVE HOME AND COMMUNITY BASED SERVICES. I FURTHER ATTEST THAT ANY SUCH SERVICES PROVIDED BY THE AGENCY WHICH I DIRECT WILL ADHERE TO SUCH REQUIREMENTS, AND WILL MAINTAIN DOCUMENTATION SUFFICIENT TO DEMONSTRATE SUCH ADHERENCE. I ACKNOWLEDGE THAT THE NYS OFFICE OF MENTAL HEALTH, THE NYS OFFICE OF ALCOHOL AND SUBSTANCE ABUSE SERVICES, OR THE NYS DEPARTMENT OF HEALTH, OR LOCAL GOVERNMENT UNITS MAY CONDUCT AN AUDIT OR INSPECTION OF (Provider- _____), INCLUDING THE RIGHT TO INSPECT ANY BOOKS OR RECORDS, INCLUDING PATIENT RECORDS, AND INTERVIEW ANY STAFF OR CLIENTS, AND THAT ANY BOOKS OR RECORDS REQUESTED BY SUCH OFFICES SHALL BE MADE AVAILABLE UPON SUCH REQUEST.

Signature of Chief Executive Officer

Telephone Number

Address

Date

COMMUNITY PSYCHIATRIC SUPPORT AND TREATMENT (CPST)

AGENCY NAME:

SITE LOCATION(S):

ANTICIPATED SERVICE HOURS PER MONTH AFTER 6 MONTHS:

Outline your expected staffing levels allotted to implement the above service:

[illegible]

Briefly state how your agency meets the criteria for providing the above service:

[illegible]

Provide a brief history of provider experience with the above service and how your agency mission is consistent with the HCBS values/core principles as articulated in section 2 of this manual.

[illegible]

HABILITATION/ RESIDENTIAL SUPPORT SERVICES

AGENCY NAME:

SITE LOCATION(S):

ANTICIPATED SERVICE HOURS PER MONTH AFTER 6 MONTHS:

Outline your expected staffing levels allotted to implement the above service:

[illegible]

Briefly state how your agency meets the criteria for providing the above service:

[illegible]

Provide a brief history of provider experience with the above service and how your agency mission is consistent with the HCBS values/core principles as articulated in section 2 of this manual.

[illegible]

FAMILY SUPPORT AND TRAINING

AGENCY NAME:

SITE LOCATION(S):

ANTICIPATED SERVICE HOURS PER MONTH AFTER 6 MONTHS:

Outline your expected staffing levels allotted to implement the above service:

[illegible]

Briefly state how your agency meets the criteria for providing the above service:

[illegible]

Provide a brief history of provider experience with the above service and how your agency mission is consistent with the HCBS values/core principles as articulated in section 2 of this manual.

[illegible]

MOBILE CRISIS INTERVENTION

AGENCY NAME:

SITE LOCATION(S):

ANTICIPATED SERVICE HOURS PER MONTH AFTER 6 MONTHS:

Outline your expected staffing levels allotted to implement the above service:

[illegible]

Briefly state how your agency meets the criteria for providing the above service:

[illegible]

Provide a brief history of provider experience with the above service and how your agency mission is consistent with the HCBS values/core principles as articulated in section 2 of this manual.

[illegible]

[illegible]

INTENSIVE CRISIS RESPITE

AGENCY NAME:

SITE LOCATION(S):

ANTICIPATED SERVICE HOURS PER MONTH AFTER 6 MONTHS:

Outline your expected staffing levels allotted to implement the above service:

[illegible]

Briefly state how your agency meets the criteria for providing the above service:

[illegible]

Provide a brief history of provider experience with the above service and how your agency mission is consistent with the HCBS values/core principles as articulated in section 2 of this manual.

[illegible]

EDUCATION SUPPORT SERVICES

AGENCY NAME:**SITE LOCATION(S):**

ANTICIPATED SERVICE HOURS PER MONTH AFTER 6 MONTHS:

Outline your expected staffing levels allotted to implement the above service:

[illegible]

Briefly state how your agency meets the criteria for providing the above service:

[illegible]

Provide a brief history of provider experience with the above service and how your agency mission is consistent with the HCBS values/core principles as articulated in section 2 of this manual.

[illegible]

[illegible]

NON-MEDICAL TRANSPORTATION

AGENCY NAME:

SITE LOCATION(S):

ANTICIPATED SERVICE HOURS PER MONTH AFTER 6 MONTHS:

Outline your expected staffing levels allotted to implement the above service:

[illegible]

Briefly state how your agency meets the criteria for providing the above service:

[illegible]

Provide a brief history of provider experience with the above service and how your agency mission is consistent with the HCBS values/core principles as articulated in section 2 of this manual.

[illegible]

PRE-VOCATIONAL SERVICES

AGENCY NAME:

SITE LOCATION(S):

ANTICIPATED SERVICE HOURS PER MONTH AFTER 6 MONTHS:

Outline your expected staffing levels allotted to implement the above service:

[illegible]

Briefly state how your agency meets the criteria for providing the above service:

[illegible]

Provide a brief history of provider experience with the above service and how your agency mission is consistent with the HCBS values/core principles as articulated in section 2 of this manual.

[illegible]

TRANSITIONAL EMPLOYMENT

AGENCY NAME:

SITE LOCATION(S):

ANTICIPATED SERVICE HOURS PER MONTH AFTER 6 MONTHS:

Outline your expected staffing levels allotted to implement the above service:

[illegible]

Briefly state how your agency meets the criteria for providing the above service:

[illegible]

Provide a brief history of provider experience with the above service and how your agency mission is consistent with the HCBS values/core principles as articulated in section 2 of this manual.

[illegible]

Example 1:**RESIDENTIAL SUPPORT SERVICES****AGENCY NAME:** Residential BH Services**SITE LOCATION:** 100 Central Avenue, New York, NY 10012**ANTICIPATED SERVICE HOURS PER MONTH AFTER 6 MONTHS:** 200**Outline your expected staffing levels allotted to implement the above service:**

Staff Title	Anticipated FTE/ Hours Per Week
Residential Supervisor	.25 / 10 hours
Residential Counselor	.50 / 20 hours
Residential Counselor	.50 / 20 hours
Residential Counselor	.25 / 10 hours

Briefly state how your agency meets the criteria for providing the above service:

Residential BH Services is licensed by the New York State Office of Mental Health and currently provides a wide range of behavioral health services for individuals of all backgrounds. Our comprehensive programs include: residential services, case management, activities of daily living, psychiatric rehabilitation, cognitive behavioral therapy, and family and community support. These existing services will be integrated into the implementation of Residential Support Services under HCBS.

Provide a brief history of provider experience with the above service and how your agency mission is consistent with the HCBS values/core principles as articulated in section 2 of this manual.

Residential BH Services has met the needs of communities in New York State for over 55 years. We provide programs in health, employment, education, housing, home care, and family and community support to over 850 individuals in 25 locations annually. Example Health and Social Services maintains a strong network of outside health and social service providers to enhance our service delivery and organizational accountability. Our mission is to promote independence and recovery, by providing a wide range of person-centered and integrated services, in effort to help each individual thrive within their home and community.

Example 2:**Psychosocial Rehabilitation****AGENCY NAME:** Recovery PROS**SITE LOCATION(S):** 54 Main Street, West NY, NY**ANTICIPATED SERVICE HOURS PER MONTH AFTER 6 MONTHS:** 260**Outline your expected staffing levels allotted to implement the above service:**

Staff Title	Anticipated FTE/ Hours Per Week
Certified Rehab Counselor	.50 / 20 hrs / week
PROS/Rehab practitioner	.75 / 30 hrs / week
PROS/Rehab practitioner	.75 / 30 hrs / week

Briefly state how your agency meets the criteria for providing the above service:

Recovery PROS has a demonstrated record of providing effective, individualized, rehabilitation services. Currently these services are provided within the structured, site-based setting of the PROS. Many individuals in our community are unable to participate in this structured setting, however, and would benefit from receiving rehabilitation services through the more flexible format offered by the 1915i service, Psychosocial Rehabilitation. Psychosocial Rehabilitation would be made available to individuals whose mental health barriers preclude their abilities to access and attend a site-based program such as PROS successfully and comfortably or for people who have graduated from a PROS service and could benefit from some limited home based rehabilitation training. Practitioners will be required to have successfully completed stringent rehabilitation training and must have demonstrated expertise in delivering rehabilitation services. All staff providing 1915i Psychosocial Rehabilitation will be supervised by a CRC.

Psychosocial Rehabilitation will be provided as a discrete 1915i service, separate and distinct from services provided as part of the site-based Recovery PROS. Interventions will be delivered face-to face with individuals, or small groups of individuals, in community-based settings of choice, other than the PROS, and in accordance with the parameters defined in the 1915i Services Manual.

Provide a brief history of provider experience with the above service and how your agency mission is consistent with the HCBS values/core principles as articulated in section 2 of this manual.

Recovery PROS has provided individualized, recovery-focused rehabilitation services within a certified, structured, site-based PROS since 2010. Our PROS has a documented record of helping individuals to achieve outstanding recovery outcomes. Individuals usually participate in PROS Services for 12 – 18 months; our data indicates that 80% of participants who leave Recovery PROS do so because they have achieved their identified life role goals. Achieved life role goals include attaining and sustaining competitive employment (25%); returning to live independently in their communities (60%); and regaining adult roles as parents and partners (65%).

Example 3:**EMPOWERMENT SERVICES- PEER SUPPORTS****AGENCY NAME:** Support Service Club**SITE LOCATION(S):** 500 W 48th Street
New York, NY 10036**ANTICIPATED SERVICE HOURS PER MONTH AFTER 6 MONTHS:** 400 hours**Outline your expected staffing levels allotted to implement the above service:**

Staff Title	Anticipated FTE/ Hours Per Week
Peer Service Coordinator	.75 / 30 hours
Peer Specialist	.50 / 20 hours
Peer Specialist	.50 / 20 hours
Peer Specialist	.50 / 20 hours
Peer Specialist	.25 / 10 hours
Clinical Supervisor	.25 / 10 hours

Briefly state how your agency meets the criteria for providing the above service:

Support Service club is an independent and private 501(c)(3) nonprofit organization that has demonstrated service delivery to individuals faced with serious mental health and substance abuse challenges. Current services and activities provided by Support Service Club are designed to encourage rehabilitation, recovery, and wellness through the use of outreach, empowerment, advocacy; social interaction; peer bridger; transitional support and acceptance-focused groups. All peer specialists providing empowerment services are certified through the New York State Offices of Mental Health.

Provide a brief history of provider experience with the above service and how your agency mission is consistent with the HCBS values/core principles as articulated in section 2 of this manual.

We pride ourselves on providing collaborative, person-centered, culturally relevant, and peer delivered services for the past 15 years. Our consumer base consists of over 500 members, from all five boroughs of New York City. Our mission is to deliver innovative and effective rehabilitation, advocacy, and support to individuals living with mental and substance abuse-related illnesses by creating an atmosphere of hope, acceptance, support and recovery. The beliefs and values of the Support Service Club directly parallel the HCBS core principles, thus making our ability to effectively provide HCBS Empowerment Services a seamless part of service delivery.

Example 4:**EDUCATION SUPPORT SERVICES****AGENCY NAME:** ABC Program**SITE LOCATION(S):** 100 Main Street, Bronx, NY 10468**ANTICIPATED SERVICE HOURS PER MONTH AFTER 6 MONTHS:** 200**Outline your expected staffing levels allotted to implement the above service:**

Staff Title	Anticipated FTE/ Hours Per Week
Certified Teacher	.5 FTE, 20 hours
Teacher Assistant	.5 FTE, 20 hours
Certified Peer Advocate	.5 FTE, 20 hours

Briefly state how your agency meets the criteria for providing the above service:

ABC has a record of providing quality education support services to individuals enrolled in the Alternative to Incarceration program as evidenced by the data demonstrating reduced recidivism and educational achievements among our participants.

Our Education program empowers clients to achieve personal and professional goals that might include earning their High School Equivalency diplomas, attending college, or preparing to enter a tough job market. Clients have the opportunity to develop essential reading, writing, math, and computer skills with the support of ABC's teachers.

The Education Department at ABC serves more than 120 students. In addition to reading, math and other traditional classes, special groups and training have evolved: computer classes and food services, and classes on how to increase employment possibilities.

Our professional educators work with each participant to develop individualized educational plans that is coordinated with the overall services plan. This includes an assessment of educational and /training needs based on employment goals that will determine the array of educational/training services that may include but is not limited to remedial education, high school equivalency education, testing, applications and financial aid.

Provide a brief history of provider experience with the above service and how your agency mission is consistent with the HCBS values/core principles as articulated in section 2 of this manual.

The ABC program has been providing educational and employment services since 2001 to individuals with serious substance use disorders through Alternatives to Incarceration funding. The ABC program has a mission to provide rehabilitative services to people who have a history of incarceration to support their long-term recovery and re-integration as fully functioning and contributing members of society.

The ABC program has successfully provided education to more than 1,000 adults and has a proven track record of program completion due to the individualized planning and attention given from our highly trained staff. In 2013 over 80% of participants completed a program that they initiated.

ABC is committed to the values and principles of Home and Community Based Services. The agency mission is aligned with the person-centered and recovery - oriented approaches envisioned in the HCBS manual. Our agency has experience working with participants who are homeless or at risk of homelessness with serious mental health and/or substance use disorders. We are committed to providing the social and community supports to increase success in community based living so that each participant thrives. The agency has been recognized as a community leader in rehabilitative services receiving an award for innovation in 2004.

The agency seeks the input of each participant through a perception of care survey and uses that information in a continuous quality improvement process. Participants frequently cite the individualized attention, support from peers and overall positive and encouraging staff attitudes as being helpful to them in attaining their goals. Many alumni return remain engaged in helping other students through our peer services project.

Chapter 5: HARP Rates Outside of New York City

HARP Rates Outside of New York City
Starts on Next Page

Region: Central
Rating Group: HARP
Contract Period: July 1, 2015 - June 30, 2016

2012 Member Months: 75,291
Trend Months: 42

Expense Type	Final Medical PMPM with Trend
Behavioral Health Medical Expenses	\$ 545.67
Acute Care Medical Expenses	\$ 812.40
Gross Medical Expenses	\$ 1,358.07
Managed Care Savings	\$ (42.12)
	-3.1%
New Benefits Adjustments	
Pharmacy	\$ 340.16
FHPlus Additional Benefits	\$ 4.49
SUD SPA Services	\$ 46.98
Stop-Loss Adjustments	
Inpatient Psych Estimated Recoveries	\$ (2.96)
General Inpatient Estimated Recoveries	\$ (4.55)
Gross Medical Expenses	\$ 1,700.07
Non-Medical Expense Loads	
Administrative Expenses	\$ 187.95
	9.9%
Underwriting Gain	\$ 19.07
	1.0%
Rates with Admin/Underwriting Gain	\$ 1,907.10

Notes:

1. CY 2012 member months are based on eligibility data for HARP eligible FFS and MC enrollees.
2. Data reflects only members age 21 and over.
3. In some cases totals may not equal the sum of their respective column components due to rounding.
4. The Inpatient Psych Stop-Loss reflects estimated recoveries under the current Inpatient Psych Stop-Loss proposal with expected managed care savings.
5. The General Inpatient Stop-Loss adjustment reflects net estimated recoveries with expected managed care savings, but does not yet reflect updates to the statewide premium to include SUD services.
6. All maternity services are excluded from this exhibit.
7. Health Homes and Medical Homes are excluded from this exhibit.
8. The rates do not include consideration for State/HIPF taxes.

Region:

Finger Lakes

Rating Group:

HARP

Contract Period:

July 1, 2015 - June 30, 2016

2012 Member Months:

83,074

Trend Months:

42

Expense Type	Final Medical PMPM with Trend
Behavioral Health Medical Expenses	\$ 410.74
Acute Care Medical Expenses	\$ 737.30
Gross Medical Expenses	\$ 1,148.04
Managed Care Savings	\$ (24.22)
	-2.1%
New Benefits Adjustments	
Pharmacy	\$ 358.24
FHPlus Additional Benefits	\$ 4.57
SUD SPA Services	\$ 25.86
Stop-Loss Adjustments	
Inpatient Psych Estimated Recoveries	\$ (1.29)
General Inpatient Estimated Recoveries	\$ (4.23)
Gross Medical Expenses	\$ 1,506.97
Non-Medical Expense Loads	
Administrative Expenses	\$ 167.05
	9.9%
Underwriting Gain	\$ 16.91
	1.0%
Rates with Admin/Underwriting Gain	\$ 1,690.93

Notes:

1. CY 2012 member months are based on eligibility data for HARP eligible FFS and MC enrollees.
2. Data reflects only members age 21 and over.
3. In some cases totals may not equal the sum of their respective column components due to rounding.
4. The Inpatient Psych Stop-Loss reflects estimated recoveries under the current Inpatient Psych Stop-Loss proposal with expected managed care savings.
5. The General Inpatient Stop-Loss adjustment reflects net estimated recoveries with expected managed care savings, but does not yet reflect updates to the statewide premium to include SUD services.
6. All maternity services are excluded from this exhibit.
7. Health Homes and Medical Homes are excluded from this exhibit.
8. The rates do not include consideration for State/HIPF taxes.

Region:

Long Island

Rating Group:

HARP

Contract Period:

July 1, 2015 - June 30, 2016

2012 Member Months:

114,795

Trend Months:

42

Expense Type	Final Medical PMPM with Trend
Behavioral Health Medical Expenses	\$ 919.41
Acute Care Medical Expenses	\$ 1,087.16
Gross Medical Expenses	\$ 2,006.57
Managed Care Savings	\$ (113.25)
	-5.6%
New Benefits Adjustments	
Pharmacy	\$ 345.06
FHPlus Additional Benefits	\$ 7.05
SUD SPA Services	\$ 57.22
Stop-Loss Adjustments	
Inpatient Psych Estimated Recoveries	\$ (14.01)
General Inpatient Estimated Recoveries	\$ (20.17)
Gross Medical Expenses	\$ 2,268.47
Non-Medical Expense Loads	
Administrative Expenses	\$ 199.67
	8.0%
Underwriting Gain	\$ 24.93
	1.0%
Rates with Admin/Underwriting Gain	\$ 2,493.08

Notes:

1. CY 2012 member months are based on eligibility data for HARP eligible FFS and MC enrollees.
2. Data reflects only members age 21 and over.
3. In some cases totals may not equal the sum of their respective column components due to rounding.
4. The Inpatient Psych Stop-Loss reflects estimated recoveries under the current Inpatient Psych Stop-Loss proposal with expected managed care savings.
5. The General Inpatient Stop-Loss adjustment reflects net estimated recoveries with expected managed care savings, but does not yet reflect updates to the statewide premium to include SUD services.
6. All maternity services are excluded from this exhibit.
7. Health Homes and Medical Homes are excluded from this exhibit.
8. The rates do not include consideration for State/HIPF taxes.

Region:

Mid-Hudson

Rating Group:

HARP

Contract Period:

July 1, 2015 - June 30, 2016

2012 Member Months:

55,512

Trend Months:

42

Expense Type	Final Medical PMPM with Trend
Behavioral Health Medical Expenses	\$ 709.64
Acute Care Medical Expenses	\$ 1,089.49
Gross Medical Expenses	\$ 1,799.14
Managed Care Savings	\$ (64.98)
	-3.6%
New Benefits Adjustments	
Pharmacy	\$ 389.80
FHPlus Additional Benefits	\$ 5.17
SUD SPA Services	\$ 69.59
Stop-Loss Adjustments	
Inpatient Psych Estimated Recoveries	\$ (6.24)
General Inpatient Estimated Recoveries	\$ (55.36)
Gross Medical Expenses	\$ 2,137.12
Non-Medical Expense Loads	
Administrative Expenses	\$ 194.48
	8.3%
Underwriting Gain	\$ 23.55
	1.0%
Rates with Admin/Underwriting Gain	\$ 2,355.14

Notes:

1. CY 2012 member months are based on eligibility data for HARP eligible FFS and MC enrollees.
2. Data reflects only members age 21 and over.
3. In some cases totals may not equal the sum of their respective column components due to rounding.
4. The Inpatient Psych Stop-Loss reflects estimated recoveries under the current Inpatient Psych Stop-Loss proposal with expected managed care savings.
5. The General Inpatient Stop-Loss adjustment reflects net estimated recoveries with expected managed care savings, but does not yet reflect updates to the statewide premium to include SUD services.
6. All maternity services are excluded from this exhibit.
7. Health Homes and Medical Homes are excluded from this exhibit.
8. The rates do not include consideration for State/HIPF taxes.

Region:

Northeast

Rating Group:

HARP

Contract Period:

July 1, 2015 - June 30, 2016

2012 Member Months:

69,318

Trend Months:

42

Expense Type	Final Medical PMPM with Trend
Behavioral Health Medical Expenses	\$ 447.45
Acute Care Medical Expenses	\$ 832.26
Gross Medical Expenses	\$ 1,279.71
Managed Care Savings	\$ (28.00)
	-2.2%
New Benefits Adjustments	
Pharmacy	\$ 366.76
FHPlus Additional Benefits	\$ 2.35
SUD SPA Services	\$ 70.10
Stop-Loss Adjustments	
Inpatient Psych Estimated Recoveries	\$ (2.77)
General Inpatient Estimated Recoveries	\$ (6.00)
Gross Medical Expenses	\$ 1,682.15
Non-Medical Expense Loads	
Administrative Expenses	\$ 186.42
	9.9%
Underwriting Gain	\$ 18.87
	1.0%
Rates with Admin/Underwriting Gain	\$ 1,887.45

Notes:

1. CY 2012 member months are based on eligibility data for HARP eligible FFS and MC enrollees.
2. Data reflects only members age 21 and over.
3. In some cases totals may not equal the sum of their respective column components due to rounding.
4. The Inpatient Psych Stop-Loss reflects estimated recoveries under the current Inpatient Psych Stop-Loss proposal with expected managed care savings.
5. The General Inpatient Stop-Loss adjustment reflects net estimated recoveries with expected managed care savings, but does not yet reflect updates to the statewide premium to include SUD services.
6. All maternity services are excluded from this exhibit.
7. Health Homes and Medical Homes are excluded from this exhibit.
8. The rates do not include consideration for State/HIPF taxes.

Region:

Northern Metro

Rating Group:

HARP

Contract Period:

July 1, 2015 - June 30, 2016

2012 Member Months:

59,123

Trend Months:

42

Expense Type	Final Medical PMPM with Trend
Behavioral Health Medical Expenses	\$ 995.36
Acute Care Medical Expenses	\$ 1,041.91
Gross Medical Expenses	\$ 2,037.27
Managed Care Savings	\$ (135.49)
	-6.7%
New Benefits Adjustments	
Pharmacy	\$ 417.50
FHPlus Additional Benefits	\$ 6.79
SUD SPA Services	\$ 24.69
Stop-Loss Adjustments	
Inpatient Psych Estimated Recoveries	\$ (23.15)
General Inpatient Estimated Recoveries	\$ (25.82)
Gross Medical Expenses	\$ 2,301.80
Non-Medical Expense Loads	
Administrative Expenses	\$ 188.31
	7.5%
Underwriting Gain	\$ 25.15
	1.0%
Rates with Admin/Underwriting Gain	\$ 2,515.26

Notes:

1. CY 2012 member months are based on eligibility data for HARP eligible FFS and MC enrollees.
2. Data reflects only members age 21 and over.
3. In some cases totals may not equal the sum of their respective column components due to rounding.
4. The Inpatient Psych Stop-Loss reflects estimated recoveries under the current Inpatient Psych Stop-Loss proposal with expected managed care savings.
5. The General Inpatient Stop-Loss adjustment reflects net estimated recoveries with expected managed care savings, but does not yet reflect updates to the statewide premium to include SUD services.
6. All maternity services are excluded from this exhibit.
7. Health Homes and Medical Homes are excluded from this exhibit.
8. The rates do not include consideration for State/HIPF taxes.

Region:

Utica-Adirondack

Rating Group:

HARP

Contract Period:

July 1, 2015 - June 30, 2016

2012 Member Months:

81,516

Trend Months:

42

Expense Type	Final Medical PMPM with Trend
Behavioral Health Medical Expenses	\$ 473.06
Acute Care Medical Expenses	\$ 647.38
Gross Medical Expenses	\$ 1,120.43
Managed Care Savings	\$ (42.07)
	-3.8%
New Benefits Adjustments	
Pharmacy	\$ 371.44
FHPlus Additional Benefits	\$ 3.41
SUD SPA Services	\$ 66.19
Stop-Loss Adjustments	
Inpatient Psych Estimated Recoveries	\$ (1.49)
General Inpatient Estimated Recoveries	\$ 1.23
Gross Medical Expenses	\$ 1,519.15
Non-Medical Expense Loads	
Administrative Expenses	\$ 181.46
	10.6%
Underwriting Gain	\$ 17.18
	1.0%
Rates with Admin/Underwriting Gain	\$ 1,717.78

Notes:

1. CY 2012 member months are based on eligibility data for HARP eligible FFS and MC enrollees.
2. Data reflects only members age 21 and over.
3. In some cases totals may not equal the sum of their respective column components due to rounding.
4. The Inpatient Psych Stop-Loss reflects estimated recoveries under the current Inpatient Psych Stop-Loss proposal with expected managed care savings.
5. The General Inpatient Stop-Loss adjustment reflects net estimated recoveries with expected managed care savings, but does not yet reflect updates to the statewide premium to include SUD services.
6. All maternity services are excluded from this exhibit.
7. Health Homes and Medical Homes are excluded from this exhibit.
8. The rates do not include consideration for State/HIPF taxes.

Region:

Western

Rating Group:

HARP

Contract Period:

July 1, 2015 - June 30, 2016

2012 Member Months:

188,442

Trend Months:

42

Expense Type	Final Medical PMPM with Trend
Behavioral Health Medical Expenses	\$ 482.63
Acute Care Medical Expenses	\$ 899.75
Gross Medical Expenses	\$ 1,382.38
Managed Care Savings	\$ (28.67)
	-2.1%
New Benefits Adjustments	
Pharmacy	\$ 329.70
FHPlus Additional Benefits	\$ 4.37
SUD SPA Services	\$ 26.33
Stop-Loss Adjustments	
Inpatient Psych Estimated Recoveries	\$ (2.73)
General Inpatient Estimated Recoveries	\$ (7.29)
Gross Medical Expenses	\$ 1,704.09
Non-Medical Expense Loads	
Administrative Expenses	\$ 176.75
	9.3%
Underwriting Gain	\$ 19.00
	1.0%
Rates with Admin/Underwriting Gain	\$ 1,899.84

Notes:

1. CY 2012 member months are based on eligibility data for HARP eligible FFS and MC enrollees.
2. Data reflects only members age 21 and over.
3. In some cases totals may not equal the sum of their respective column components due to rounding.
4. The Inpatient Psych Stop-Loss reflects estimated recoveries under the current Inpatient Psych Stop-Loss proposal with expected managed care savings.
5. The General Inpatient Stop-Loss adjustment reflects net estimated recoveries with expected managed care savings, but does not yet reflect updates to the statewide premium to include SUD services.
6. All maternity services are excluded from this exhibit.
7. Health Homes and Medical Homes are excluded from this exhibit.
8. The rates do not include consideration for State/HIPF taxes.

NYC Approved Behavioral Health Medicaid Managed Care Plans

Plan Name	Conditional Designation Status	Partnering with BHO	Plan Contact Information for Providers	
AFFINITY HEALTH PLAN INC	Mainstream	Beacon Health Options	Alisa Simmons Director, State Government Programs Operations Address: Affinity Health Plan 2500 Halsey Street Bronx, NY 10461 Phone: 718-794-5802 Email: asimmons@affinityplan.org	William J. Carboni AVP of Network Development Address: Beacon Health Options 500 Unicorn Park Drive, Suite 103 Woburn, MA, 01801 Office: 781.496.4771 Cell: 781439.2932 Email: www.beaconhealthoptions.com William.carboni@beaconhs.com
AMERIGROUP NEW YORK LLC	Mainstream/HARP	No	Jessica Jordan Address: 9 Pine Street, NY 10005 Phone: 212-563-5570 ext 64321 Email: Jessica.Jordan@amerigroup.com	
AMIDA CARE INC (HIV SNP)	Mainstream/HIVSNP	Beacon Health Options	Michele Pedretti-Moussally, LMSW Senior Director of Behavioral Health Amida Care Address: 14 Penn Plaza, 2 nd floor New York, NY 10122 phone: (646) 757-7625/fax: (646) 786-1802 email: mpedretti@amidacareny.org website: www.amidacareny.org	William J. Carboni AVP of Network Development Address: Beacon Health Options 500 Unicorn Park Drive, Suite 103 Woburn, MA, 01801 Office: 781.496.4771 Cell: 781439.2932 Email: www.beaconhealthoptions.com William.carboni@beaconhs.com
HEALTH FIRST PHSP INC	Mainstream/HARP	No	Dedicated Contractors: <ul style="list-style-type: none"> Brenda Pauta (646) 767-4229 bpauta@healthfirst.org Ann Nurse (212) 801-6257 anurse@healthfirst.org Dedicated Network Provider Reps Lori Campbell (347) 574-6589 lcampbell@healthfirst.org <ul style="list-style-type: none"> Maurice White (646) 767-5185 mwhite@healthfirst.org Claims Assistance <ul style="list-style-type: none"> Nechama Chipantiza (212) 401-8403 NChipantiza@HealthFirst.org 	

April 8, 2015

Plan Name	Conditional Designation Status	Partnering with BHO	Plan Contact Information for Providers
			<ul style="list-style-type: none"> Raushanah Jones (212) 401- 8557 RauJones@Healthfirst.org
HLTH INSURANCE PLAN OF GTR NY (EMBLEM)	Mainstream/HARP	Beacon Health Options	<p>William J. Carboni AVP of Network Development</p> <hr/> <p>Address: Beacon Health Options 500 Unicorn Park Drive, Suite 103 Woburn, MA, 01801</p> <p>Office: 781.496.4771</p> <p>Cell: 781439.2932</p> <p>Email: www.beaconhealthoptions.com William.carboni@beaconhs.com</p>
METROPLUS PARTNERSHIP CARE and HIV SNP	Mainstream/HARP/HIVSNP	Beacon Health Options	<p>William J. Carboni AVP of Network Development</p> <hr/> <p>Address: Beacon Health Options 500 Unicorn Park Drive, Suite 103 Woburn, MA, 01801</p> <p>Office: 781.496.4771</p> <p>Cell: 781439.2932</p> <p>Email: www.beaconhealthoptions.com William.carboni@beaconhs.com</p>
NYS CATHOLIC HEALTH PLAN INC (FIDELIS CARE)	Mainstream/HARP	No	<p>Courtney E. Gagnon Senior Contract Management Representative Fidelis Care New York</p> <p>Address: 31 British American Boulevard Latham, New York 12110</p> <p>Phone: (518) 445-3901 Fax: (518) 320-7354</p> <p>Email: cgagnon@fideliscare.org</p>
UNITED HEALTHCARE OF NY INC	Mainstream/HARP	Optum	<p>Afrika Zyonne-Kumani, Network Manager, Behavioral Health Services</p> <p>Phone: 518-313-4871</p> <p>Email: afrika.zyonne-kumani@uhc.com</p> <p>Allandro, Pierre, Network Manager, Behavioral Health Services</p> <p>Phone: 952-202-3839 Email: Allandro.Pierre@uhc.com</p>

April 8, 2015

Plan Name	Conditional Designation Status	Partnering with BHO	Plan Contact Information for Providers
VNS CHOICE SELECT HEALTH (HIV SNP)	Mainstream/ HIVSNP	Beacon Health Options	<p>William J. Carboni AVP of Network Development</p> <hr/> <p>Address: Beacon Health Options 500 Unicorn Park Drive, Suite 103 Woburn, MA, 01801</p> <p>Office: 781.496.4771</p> <p>Cell: 781439.2932</p> <p>Email: www.beaconhealthoptions.com William.carboni@beaconhs.com</p>
WELLCARE OF NEW YORK INC	Mainstream	No	<p>Primary: Jason Young (Jason.Young@wellcare.com) 917-229-1981</p> <p>Secondary: Edward Elles (Edward.Elles@wellcare.com) 917-229-1998</p>

Links to Managed Care Plan Handbooks

Some are listed without links to their provider manuals because they only allow access to contracted providers. However, we are still working on getting them. They appear in alphabetical order.

- **Affinity Health Plan**

http://affinityplan.org/uploadedFiles/Affinityv2/Content/Providers/Provider_Resources/2013_1021_Provider_Directory_111413.pdf

- **Amerigroup, Inc.**

https://providers.amerigroup.com/ProviderDocuments/NYNY_CAID_HP_ProviderManual.pdf

- **Amida Care (HIV/AIDS)**

http://livelifeplus.amidacareny.org/Collateral/Documents/English-US/Provider_Manual.pdf

- **CDPHP**

- **Excellus Health Plan**

<https://www.excellusbcbs.com/wps/wcm/connect/b5d65f19-838e-4232-a7f3-b319aecc3565/Excellus+Provider+Manual+%2714+Update+FINAL+COMBINED+for+WEB.pdf?MOD=AJPERES&CACHEID=b5d65f19-838e-4232-a7f3-b319aecc3565>

<https://www.excellusbcbs.com/wps/wcm/connect/68745090-37f0-459d-a363-49acd4b96e1f/10GovernmentPrograms.pdf?MOD=AJPERES&CACHEID=68745090-37f0-459d-a363-49acd4b96e1f>

- **HIP of Greater NY**

- **HealthFirst PHSP**

http://assets.healthfirst.org/api/pdf?id=pdf_1f8303d96c&key=29fbef90cdbfc0620f55f8f6e4667453767cf00a

- **HealthNow NY, Inc.**

https://securews.healthnowny.com/web/content/dam/HNNY/Provider/ProviderManuals/Reference_Manual_HNNY.pdf

- **Hudson Health Plan**

- **Independent Health Association**

- **MetroPlus Health Plan (HIV-SNP)**

http://www.metroplus.org/docs/provider_manual.pdf

- **MVP Health Plan**

http://www.mvphealthcare.com/provider/documents/MVP_Health_Care_ProviderResourceManualSection6.pdf

<http://www.mvphealthcare.com/SearchEngine/SearchEngineResults.html?q=provider%2Bmanual%2Bsection>

- **Neighborhood Health Providers**

https://www.nhp.org/provider/Documents/ProviderManual_Beacon.pdf

- **NYS Catholic Health Plan Fidelis**

<http://www.fideliscare.org/providers/providermanual.aspx>

- **PCMP II-A Gold Choice**

https://www.emedny.org/ProviderManuals/AllProviders/PDFS/archive/Information_for_All_Providers-Managed_Care_Information_2010-1.pdf

- **SCHC Total Care, Inc.**

<http://www.totalcareny.com/documents/199.pdf>

- **Southern Tier Pediatrics**

- **Southern Tier Priority Healthcare**

- **United Health Care of NY**

https://www.unitedhealthcareonline.com/ccmcontent/ProviderII/UHC/en-US/Assets/ProviderStaticFiles/ProviderStaticFilesPdf/Tools%20and%20Resources/Policies%20and%20Protocols/TRICARE_Provider_Handbook_October_2014.pdf

- **Univera Community Health**

https://www.univerahealthcare.com/wps/wcm/connect/3bcc6af3-20b1-460c-92a3-c04984adaf87/UCH_ProviderManual%2714+UpdateFINALcombinedforWEB.pdf?MOD=AJPERES

- **VNSNY CHOICE SelectHealth**

https://www.vnsnychoice.org/sites/default/files/VNSNY_CHOICE_Health_Plans_Provider_Manual.original%20v122713%20for%20web.pdf

- **Wellcare of NY, Inc.**

https://www.wellcare.com/WCAAssets/newyork/assets/ny_medicaid_provider_manual_05_2013.pdf

New York Third Party Billers

Specialization: Mental Health

COMPANY	CONTACT	ADDRESS	PHONE	FAX	WEBSITE
4D Medical	Ms. Chanie Gluck President	1250 Broadway 36th Floor New York, NY 10001	718-336-6322	888-977-3383	http://www.4dmed.com
Bill Of Health Services, Inc.	Madelon I. Berger MPH, MA, CCS-p, CPC President	17 Squadron Blvd., Suite 400 New City, NY 10956-5231	845-213-1490 914-527-2400	845-634-9424	http://www.billofhealthservices.com
BTQ Financial	Mr. David S. Terrio	80 Broad Street, 15th Floor New York, NY 10004	212-901-2445	917-608-9568	http://www.btqfinancial.com
KeyMed Partners, Inc.	Joni M. Long Vice President	9 Mandy Lane Dillsburg, PA 17019	717-364-3022 717-580-6724	717-214-3009	http://www.keymedpartners.com
Medical Billing of Metro NY	Ms. Joanne M. Nolan President/Owner	212 First Ave Massapequa Park, NY 11762	516-541-3930	516-541-3937	http://www.mbmny.net
Medical Business Associates, Inc.	Ms. Jeanne Rizzo, CHBME Owner/President	46 Elm St. Glens Falls, NY 12801	518-793-9820	518-793-7517	
Medical Claims & Billing Services	Ms. Laura Markowitz President	1515 Summer St, Apt 301 Stamford, CT 06905	203-329-8195	203-653-5148	
CloudRev Medical	Mr. Jesus Rueda CEO / Co-founder / Director	303 10th Avenue, Suite 7A New York, NY 10019	646-902-7775 704-451-1339		http://www.cloudrevmed.com
Faculty Practice Services, Inc.	Mr. Barry S. Reiter Principal	343 East 33rd Street Suite 2E New York City, NY 10016	212-889-5964 917-335-6999		http://www.fpsinc.org
Healthcare Billing Consultants Inc.	Mrs. Melissa Helsel	721 Lingle Street Osceola Mills, PA 16666	814-339-7869 814-339-7101	814-339-6165	http://www.hbcinc.biz
Medical Data Consultants, Inc.	Mr. Asher Gancz	101 Broadway Suite B01 Brooklyn, NY 11249	718-963-3495	718-963-3496	http://mdcbill.com
Medical Office Support Services	Mr. Jonathan A. Schuessler, MBA President	107 Hammond Lane Plattsburgh, NY 12901	518-561-1603 800-789-2455	518-561-0179	http://www.anesthesiabill.com
MediGain	Robert Romero VP Business Development	2800 Dallas Pkwy, Suite 200 Plano, TX 75093	972-675-7354 972-897-7057		http://www.medigain.com
Pacific Global, Inc.	Mr. Shwetabh Kumar, MBA CEO	1013 Centre Road Suite 403 S Wilmington, DE 19805	510-870-0248	646-416-2244	http://www.pacificbpo.com
Physician's Medical Management Co.	Mr. Andrew D. Archer	111 Wales Ave Tonawanda, NY 14150	716-633-7600	716-633-7281	http://www.phymedco.com
Practicare Medical Management, Inc.	Mr. James N. Antonacci President/CEO	4567 Crossroads Park Drive Liverpool, NY 13088	315-295-2100 315-433-5161	315-295-2125	http://www.Practicare.net

New York Third Party Billers

Specialization: Mental Health

COMPANY	CONTACT	ADDRESS	PHONE	FAX	WEBSITE
Precision Practice Management	Ms. Danielle Carroll, CPC Manager of Clinical Services	689 Craig Road St. Louis, MO 63141	314-787-0681	314-787-0691	http://www.precisionpractice.com
Professional Data Management, Inc.	Mr. Mitchell A. Ivey President	309 N William Street Goldsboro, NC 27530	866-584-9382 919-920-5297	866-205-0732	http://www.prodatamgmt.com
Strategic Solutions	Lori Jenkins, CPA President	3 Corporate Drive Clifton Park, NY 12065	Ask for Barb 518-348-1276 877-643-2336		http://www.strategicsolutionsmgmt.com



List of Medicaid Managed Care Companies and the Counties in which they Operate

Non Profit / For Profit 6/3/2014

Company Names ▶	Total # of Counties & Lives Covered ▼	Affinity Health Plan	Amerigroup, Inc.	Amida Care (HIV/AIDS)	CDPHP	Excellus Health Plan	HIP of Greater NY	HealthFirst PHSP	HealthNow NY, Inc.	Hudson Health Plan	Independent Health Association	MetroPlus Health Plan	MetroPlus Health Plan (HIV-SNP)	MVP Health Plan	Neighborhood Health Providers	NYS Catholic Health Plan Fidelis	NY Presbyterian CHP	SCHC Total Care, Inc.	Today's Options of NY, Inc.	United Health Care of NY	Univera Community Health	VNSNY CHOICE SelectHealth (HIV-SNP)	Wellcare of NY, Inc.
Counties Covered ▶	225	10	7	5	12	12	8	7	6	6	2	4	4	10	6	62	4	3	3	38	4	4	11
Covered Lives ▶	4,652,867	261,710	108,589	4,819	228,250	277,675	731,334	502,962	125,121	112,067	176,658	411,927	5,653	257,487	209,460	715,108		27,000	60,000	307,822	48,185	6,236	74,804
Albany	5				Albany									Albany		Albany				Albany			Albany
Allegany	3								Allegany							Allegany					Allegany		
Bronx	13	Bronx	Bronx	Bronx			Bronx	Bronx				Bronx	Bronx		Bronx	Bronx	Bronx			Bronx		Bronx	Bronx
Broome	4				Broome	Broome										Broome				Broome			
Cattaraugus	2								Cattaraugus							Cattaraugus					Cattaraugus		
Cayuga	2															Cayuga				Cayuga			
Chautauqua	4								Chautauqua							Chautauqua				Chautauqua	Chautauqua		
Chemung	2															Chemung				Chemung			
Chenango	2															Chenango				Chenango			
Clinton	2															Clinton				Clinton			
Columbia	3				Columbia											Columbia				Columbia			
Cortland	3															Cortland		Cortland	Cortland				
Delaware	1															Delaware							
Dutchess	3									Dutchess						Dutchess							Dutchess
Erie	5					Erie			Erie		Erie					Erie					Erie		Erie
Essex	2															Essex				Essex			
Franklin	1															Franklin							
Fulton	3				Fulton											Fulton				Fulton			
Genesee	3													Genesee		Genesee				Genesee			
Greene	2				Greene											Greene							
Hamilton	1															Hamilton							
Herkimer	3					Herkimer										Herkimer				Herkimer			
Jefferson	3													Jefferson		Jefferson							
Kings	13	Kings	Kings	Kings			Kings	Kings				Kings	Kings		Kings	Kings	Kings			Kings		Kings	Kings
Lewis	2															Lewis				Lewis			
Livingston	3					Livingston								Livingston		Livingston							
Madison	2															Madison				Madison			
Monroe	4					Monroe								Monroe		Monroe				Monroe			
Montgomery	2				Montgomery											Montgomery							
Nassau	6	Nassau	Nassau				Nassau	Nassau								Nassau				Nassau			
New York	13	New York	New York	New York			New York	New York				New York	New York		New York	New York	New York			New York		New York	New York
Niagara	3										Niagara					Niagara				Niagara			
Oneida	3					Oneida										Oneida				Oneida			
Onondaga	4															Onondaga		Onondaga	Onondaga	Onondaga			
Ontario	4					Ontario								Ontario		Ontario				Ontario			
Orange	5	Orange								Orange						Orange				Orange			Orange
Orleans	3					Orleans			Orleans							Orleans							
Oswego	3															Oswego				Oswego			
Otsego	2					Otsego										Otsego							
Putnam	2		Putnam													Putnam							
Queens	13	Queens	Queens	Queens			Queens	Queens				Queens	Queens		Queens	Queens	Queens			Queens		Queens	Queens
Rensselaer	5				Rensselaer									Rensselaer		Rensselaer				Rensselaer			Rensselaer
Richmond	8	Richmond	Richmond	Richmond			Richmond	Richmond							Richmond	Richmond				Richmond			
Rockland	5	Rockland								Rockland						Rockland				Rockland			Rockland
Saratoga	3				Saratoga									Saratoga		Saratoga							
Schenectady	3				Schenectady									Schenectady		Schenectady							
Schoharie	2				Schoharie											Schoharie							
Schuyler	1															Schuyler							
Seneca	3					Seneca										Seneca				Seneca			
St.Lawrence	2															St.Lawrence				St.Lawrence			
Steuben	1															Steuben							
Suffolk	6	Suffolk					Suffolk	Suffolk							Suffolk	Suffolk				Suffolk			
Sullivan	2									Sullivan						Sullivan							
Tioga	3				Tioga											Tioga				Tioga			
Tompkins	3															Tompkins		Tompkins	Tompkins				
Ulster	4									Ulster						Ulster				Ulster			Ulster
Warren	2													Warren		Warren				Warren			
Washington	2				Washington											Washington							
Wayne	2					Wayne										Wayne				Wayne			
Westchester	5	Westchester					Westchester			Westchester						Westchester				Westchester			
Wyoming	2								Wyoming							Wyoming							
Yates	2					Yates										Yates							