

## **APG Managed Care Implementation Questions**

Updated May 14, 2012

### **Definition**

#### **1. What is the definition of a “government rate”?**

NYS statute mandates that mental health clinic reimbursement “shall be in the form of fees for such services which are equivalent to the payments established for such services under the ambulatory patient group (APG) rate-setting methodology”. The term “government rate” is used to represent the Medicaid fee-for-service (FFS) APG rates.

### **Plans affected by the Statute**

#### **2. Will Family Health Plus (FHP) be included in this mandate? What about Child Health Plus (CHP)?**

Yes, Family Health Plus Plans are included. Child Health Plus Plans are not.

#### **3. If the Plans offer a SNP Duals product will the mandate apply to it?**

Medicare enrollees cannot currently enroll in MMC.

#### **4. Will implementation of “government rates” be mandatory even if a Plan and a particular provider agree not to move to APGs?**

Plans must pay using the APG methodology. It would be allowable for a Plan to contract with a provider for reimbursement that is greater than the government rate.

#### **5. Do the “government rates” apply to any other providers besides OMH licensed clinics?**

Yes. “Government rates” apply to procedures outlined in Part 599 delivered in hospital outpatient departments and Diagnostic and Treatment Centers not licensed by OMH.

#### **6. Does the requirement for “government rates” include OASAS providers?**

No.

### **Rates**

#### **7. How is the rate calculated?**

The payments to all providers eligible for “government rates” are “procedure-based”, using the APG system. The APG peer group base rate was calculated using 08-09 visit volume,

procedures delivered, and the historic fees/rates for clinic services. The provider specific blend rate was based on the 08-09 visit volume and the September 30, 2010 supplemental rate (COPS). The CSP add-on **is not** included in the blend “government rate”. The blend rates are phasing out over 4 years. (The hospital-based clinics have already transitioned to 100% APG base rates. The balance of OMH licensed clinics will receive blend rates through September 30, 2013.)

**Note:** The CSP add-on is a supplemental payment to support rehab and support activities delivered by the same agency.

**8. What are the rates to be paid?**

“Government rates” under this initiative will likely be (not yet approved by control agencies) 100% of the APG rates for each clinic type (peer group). The final rates will be determined in May 2012. The most up-to-date list of FFS mental health clinic APG base rates and provider specific blend rates can be found on the [OMH website](#). The list of “government rates” will be added to the OMH website after approval by the control agencies. (The blend rate for so-called “government rates” will not include the CSP add-on. However, the published blend rates found at the link above DO include CSP where applicable.) Managed Care Organizations (MCOs) will be required to pay a capital add-on for procedures provided in hospitals.

**9. Will these rates take into account the quality incentive? If so, will this be rolled into the rates or is there an additional payment that plans will need to make to providers for meeting the quality incentive?**

The OMH QI is included. The QI incentive is included in the APG peer group base rates. OMH will post a list of QI providers on the OMH website.

**10. Will DOH and OMH only be posting the APG base rates online or will they include the provider-specific blend rates?**

The provider-specific blend rates and APG peer group base rates are posted on the [OMH website](#). **Note:** The list of “government rates” will be added to the OMH website after approval by the control agencies. (The blend rate for “government rates” will not include the CSP add-on. However, the published blend rates found at the link above DO include CSP where applicable.) MCOs will be required to pay a capital add-on for procedures provided in hospitals.

**11. Will the CSP portion of the blend payment be paid by the Plans?**

No. Plans will be required to pay equivalent to the provider-specific blend rate portion of payment **excluding** CSP.

**12. Will specialty clinic providers continue to bill Medicaid fee-for-service for Medicaid managed care children who have been determined to be seriously emotionally disturbed (SED) (carved out services) or will the providers need to bill the Plans?**

Yes, Specialty Clinics will continue to bill Medicaid FFS directly for Medicaid managed care SED children.

**MCO Premiums**

**13. How will the MCOs be paid?**

Plans will receive an increase to their capitation premiums.

**14. Will the Plans be paid up front or on the back end? Will this additional money be designated for outpatient mental health services?**

The additional funds will be included in the monthly premiums. The increase will not be designated for outpatient mental health services; however, we will be monitoring the number of encounter claims for significant changes.

**15. When can Plans expect to receive the premium adjustment to account for the rate increase?**

There will be a July 2012 premium period which will include this adjustment.

**16. Are extra, unused COPS funds which are expected to fiscally support the MCOs paying “government rates” expected to run out at some point? If so, when would OMH expect these funds to run out? If they do run out, what funding stream could take their place?**

All of the blend rates, base rates, “government rates” are built into the state’s fiscal plan. The APG rates including “government rates” are anticipated to continue when the blend transition period is over. (APG base rates and procedure weights are subject to reweighting in the future.)

**MCO reporting requirements**

**17. Will there be any specific DOH/OMH reporting requirements beyond service encounters?**

There are no additional OMH or DOH reporting requirements.

**18. Will the change in funding now trigger Medicaid to audit managed care visits when they do provider audits?**

OMIG designs audit protocols. Neither OMH nor DOH has requested an audit change due to this funding change.

**Transition to “government rates”**

**19. The free-standing clinics are currently transitioning to APGs. Will there be an accompanying change in the transition schedule (i.e., sped up)?**

There will be no change in the transition schedule.

**20. What happens to COPS-only payments when “government rates” commence?**

COPS-only payments will cease for dates of service on and after the day that “government rates” begin.

**21. Will there be a timeframe for implementation? When will the payment requirement become effective?**

July 1, 2012 is the implementation date for the APG rate methodology.

**22. Is there a hardship concession allowed to get an extension to the implementation date?**

No.

**23. Full implementation of the APG grouper will take a significant amount of time. Can Plans reimburse providers a rate equivalent to APGs to keep them whole while they work on implementing the APG grouper and methodology? We would still be paying them a "mirror" rate but outside of the APG grouper.**

Plans must pay using the APG payment methodology. Third party calculation of APGs or processing of APG payments is permissible.

**24. Is it mandatory that the 3M Grouper be purchased by the MCOs? Or will it be allowable for the MCOs to just load the rate schedule into their systems?**

No, it is not required that the grouper be purchased by the Plans. The Plans can load the rate schedules into their systems. However, any system a Plan develops must produce the same payment results as the 3M APG Grouper.

**25. Does DOH plan to affect uniformity over MCOs regarding policies and procedures related to day to day operations occurring between providers and MCOs? Standardized forms and procedures would greatly simplify business between providers and MCOs.**

DOH does not prescribe forms.

**26. If a recipient switches MCO plans, which the provider may not be aware of, can providers be allowed a 180-day grace period to process denials, obtain authorization and re-bill the proper MCO?**

- The Department of Health encourages providers to confirm eligibility (and therefore enrollment) at every visit or on the first and fifteenth of every month for those enrollees with continuing services so that contact can be made to the new MCO promptly.
- PHL 4403(6) (f) provides for a 60-day transitional period when a new enrollee has a life threatening, degenerating or disabling disease or condition, or, if the enrollee is in the second semester of a pregnancy, a transitional period including post-partum care related to the delivery, when the enrollee is being treated by a provider that is not in the MCO's network. The Department has issued the "Medicaid Managed Care and Family Health Plus Coverage Policy: New Managed Care Enrollees in Receipt of an Ongoing Course of Treatment" for application of this requirement for Medicaid managed care and Family Health Plus enrollees. In summary, if the provider is not participating with the new plan, transitional care services must be provided for up to 60 days or until the plan has assessed the member's needs and an approved treatment plan is put into place. The plan's obligation to ensure the continued provision of services, including services authorized under Medicaid fee-for-service or by another Medicaid managed care or Family Health Plus plan, during the 60-day transition period applies even if the non-participating provider fails to notify the plan or request authorization. The plan should also ensure that reimbursement issues do not interfere with continuity of care. In the absence of a negotiated rate, the Department suggests that plans reimburse non-participating providers at the Medicaid fee-for-service rates. Plan policies and procedures for participating providers must include a mechanism to secure prior authorization within a reasonable period after the effective date of enrollment and assure continuity of care during the transitional period.
- If the provider is participating in both plans, the policies and procedures for authorizations and billing must be followed as per the provider's contract with the plan.
- If the provider is not participating with the new plan, Social Services Law provides that the provider has 15 months from the date of service to submit a claim for Medicaid managed care/FHP covered services, but services other than emergency services likely

require prior authorization from the plan to be eligible for payment. Participating providers must have at least 90 days from the date of service to submit the claim.

**27. Will OMH/DOH set up a binding arbitration unit with specific processes and time frames to settle disputes between providers and MCOs?**

The providers should utilize the plans' appeal processes and existing DOH processes (e.g., fair hearings, appeals).

**Contracts**

**28. Will contracts with providers need to change?**

Some provider contracts will need to change. Some Plans have contracts saying the provider will be reimbursed according to the FFS reimbursement methodology in effect on the date of service, so those contracts would not need to change. The contracts between the State and the Health Plans will likely need some change (though the statute may be sufficient).

**29. Is it mandated to apply APG methodology to ALL of our (MCO-Clinic) current contracts, or would this methodology just apply to newly contracted providers? We have just completed contract negotiations with most of the mental health providers that will be affected.**

Yes. The mandate applies to all existing and future contracts.

**30. Do Plans need to contract with all willing providers for mental health services?**

No. Plans are expected to continue their existing contracts with clinics. Plans are also encouraged to contract with additional clinics.

**31. Will Plans be required to reimburse for services provided by staff not empanelled by their organization?**

Payment for non-empanelled licensed staff approved under Part 599 Clinic regulations and employed by the clinic will be required. Payment for some non-licensed staff will also be required. OMH is developing guidance on this issue which will be available soon.

**Services**

**32. Are the Plans required to make available all services included in Part 599?**

Yes. The Plans are required to make available “in an accessible manner” all Part 599 procedures to all members of their plan. However, Plans will NOT be required to purchase all Part 599 procedures at each clinic.

**33. Will Plans cover crisis services for all providers? If so, can agencies provide crisis services without authorization?**

Yes, all levels of crisis must be reimbursed if provided by the clinic in compliance with Part 599 rules. For more information on crisis services see the OMH Part 599 guidance document: [http://www.omh.ny.gov/omhweb/clinic\\_restructuring/part599/guidance.pdf](http://www.omh.ny.gov/omhweb/clinic_restructuring/part599/guidance.pdf)

**34. Can agencies provide complex care management without an authorization?**

Yes, complex care is not a distinct service but is ancillary to a crisis or individual psychotherapy service. If the underlying service is authorized then the CCM does not need to be authorized.

**35. Will Plans accept the Part 599 modifiers and pay the enhanced rates?**

- Physician add-on: Plans will be required to pay the physician add-on so long as the underlying service has been authorized.
- After-hours add-on: The after-hours add-on is required so long as the clinic license indicates later hours as defined in Part 599.
- Language other than English (LOE) add-on: LOE is required if initially authorized. The Plans will authorize for LOE once for the entire course of treatment.
- School-based Group Psychotherapy: The payment reduction modifier is required so long as the duration of the service is that of the school period provided the school period is of duration of at least 40 minutes.

**36. Are Plans required to pay for off-site services at APG rates?**

Reimbursement for off-site services is subject to medical necessity determination by the Plans. However, if MCOs approve off-site services, they must be paid at the 150% APG rate. This rate applies only to a subset of services which can be found on page 26 of the Part 599 guidance document.

[http://www.omh.ny.gov/omhweb/clinic\\_restructuring/part599/guidance.pdf](http://www.omh.ny.gov/omhweb/clinic_restructuring/part599/guidance.pdf)

**37. Will Plans reimburse for 2 or more procedures per day, consistent with Part 599?**

Yes, subject to medical necessity limitations and Plan/clinic contractual requirements regarding services covered by the managed care plan and plan-specific requirements for authorization for procedures. As with fee-for-service Medicaid claims, the lower weighted service will be discounted by 10%.

**38. Will this change affect Medication access and reimbursement for Injectables?**

No, the change will not affect medication access; however, OMH/DOH are exploring the issue of payment for injectables and will provide further guidance in the near future.

**Utilization Review**

**39. Will managed care companies have utilization restrictions?**

Managed Care Plans may, at their discretion, require prior authorization and perform utilization review.

**40. Are there reductions in payment associated with utilization limits such as the 30-50 visit requirements in fee-for-service?**

No, these reductions only apply to clinic visit volume reimbursed fee-for-service through eMedNY.