Part 599 – Clinic Treatment Programs
Response to 14 NYCRR Part 599 Express Terms
Submitted by The Coalition of Behavioral Health Agencies, Inc.
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Regulatory Impact Statement

Costs

SOMH asserts that the only groups to lose financially under Part 599 are those organizations "that have low productivity." "Therefore," OMH concludes, "providers in these groups have the chance to significantly mitigate their losses by improving their productivity. This is an outcome OMH wishes to encourage."

The Coalition disagrees strongly with this assertion, having conducted a revenue analysis that employs a projection tool designed by the State Office of Mental Health. Our sample consisted of 20 community based providers in New York City, Westchester, Nassau and Suffolk counties. These providers sponsor 73 clinics which the analysis shows to be broadly representative of all downstate clinics. The analysis further shows that productivity is only one factor, among many, in the loss of revenues for clinics. The complexity of the restructuring will result in considerable losses for many clinics through each of the four years of the phase-in and thereafter.

Job Impact Statement

OMH asserts that there "will be no adverse impact on the jobs and employment opportunities as a result of this rulemaking."

The Coalition disagrees strongly with this assertion. The Coalition's analysis shows an adverse impact on organizations that staff their clinics with mostly salaried professional employees with benefits. These providers will proportionately have much greater costs and lower financial viability than those agencies adopting a model of staffing with unsalaried, hourly, fee-for-service professionals. We believe this result to have a negative impact on the quality of the workforce. It will hamper the ability of the field to attract high quality professionals and be detrimental to the resultant quality and continuity of care. The restructuring has the effect of pushing clinics toward the latter model of professional staffing in order to remain fiscally viable.

General Concerns

1) Laudably, the proposed new system allows access to an indigent care pool that will, hopefully, permit Article 31 community based clinics to continue providing care to uninsured individuals. We are concerned about the significantly lower reimbursements for indigent care that likely will result in reduced access for uninsured individuals to community based clinics. These free standing programs provide specialized "gold standard care."

   Moreover, the Article 31 clinic system historically has provided care to the working poor and middle class populations who have commercial insurance. The very low payments granted by commercial insurers, way under the unit cost of providing care, has forced some clinics to stop serving these New York residents and will likely reduce their access to the community based system that so many of these people have relied upon for their often significant mental health needs. This is an equality of access issue that must be addressed by policy makers.

2) Despite an understanding by stakeholders that the new regulations would be simple and provide burden relief, a review of the 14 NYCRR Part 599 Express Terms shows the contrary to be the case. The regulations are enormously complex, dense in part and difficult to interpret, particularly the sections related to the medical assistance reimbursement system. **Recommendation: Part 599.13 and 14 should be written as an operations manual,** hopefully making the sections clearer and more understandable. At the same time that we make this recommendation, we have grave concerns about the proliferation of governing documents such as regulations, Guidance documents and FAQs. We think that multiple documents will create confusion, generate conflicting sources of authority and make it easier for auditing bodies and OMIG to find behavioral noncompliance.

   In addition, we have the following concerns:

   - Given the complexity of the regulations, and many issues still not clear, software companies will have an extremely difficult time making necessary edits in a timely fashion.

- The restructuring reimbursement methodology has made it very difficult for providers to predict revenue. In order to project budget revenues, shadow bill and verify reimbursement, providers will have to purchase the 3M APG software or pay their vendor to create a like system.
- The organization of the regulations seems neither intuitive nor logical and finding topics is extremely difficult. For example, utilization review is in the Organization and Administration section of the regulations.
- We are awaiting instructions on how to bill for health screening and health physicals as well as payment amounts.
- We seek clarification and distinction between the terms "admitted" and "enrolled."

As stated above, OMH has repeatedly promised regulatory relief as part of the restructuring process and it is difficult to identify much relief in these regulations (except for allowable second service in a single day). There are increased requirements in these regulations in multiple areas, including (but not limited to):

- Increased risk assessments, wellness screenings, etc.
- Requirement to ensure enrollment of eligible uninsured clients in Medicare or Medicaid without payment for benefits management specialists
- All new IT demands (unfunded) for billing APGs, modifiers, checking addresses of consumers to prevent multiple off-site bills at same location, allowing multiple same day services to be billed, etc.

3) The regulations offer little protection from an OMIG audit. It is essential that the regulations, guidance documents and operations manuals be agreed to in advance by OMH, OMIG and DOH in order to put predictable boundaries on providers' liabilities for delivery and billing of clinic services.

4) OMH should develop transition plans/templates and a reasonable time frame that will help providers fulfill mandates for plan approvals e.g. determination of who are "homebound", 24 hour crisis intervention services—and all other mandates requiring an approved plan.

5) We seek definition and examples of operational manifestations of “clinical home” designation.

Recommendations for Clinic Restructuring

1) These regulations should become effective no earlier than six (6) months following the adoption of the regulations. Lacking some Federal approvals and interdepartmental agreements, we think the regulations should go into effect in its entirety, and not in a piecemeal fashion. Software vendors will require lead time from adoption in order to make the necessary changes to electronic billing and tracking systems.

2) Providers should be permitted to adhere to CMS approved Medicaid standards of billing for 30 minute visit at same rate as 45 minute visit;

3) SOMH should reinstate a brief visit (15-29 minutes) in the array of services and it should be weighted appropriately.

4) OMH should establish a peer group with higher base rate for clinics that employ 70% of salaried clinical professionals receiving benefits, including health care;

5) We seek peer group and rate parity with counties for downstate voluntary providers; the significantly higher rate for county providers is discriminatory, especially since reimbursement should be based on service to individuals and their needs, not on the basis of the basis of sponsoring entity.

6) Article 31s should have parity with Article 28s with respect to capital pass-throughs;

7) OMH should provide training and billing methodologies in order to assist providers to implement screening and assessment for substance abuse and co-occurring disorders, as required by regulations;

8) OMH should offer a subsidy/pass through for the extensive technology changes (hardware and software) engendered by these new regulations and for costs of joining RHIOS and other required health information technology enhancements.

Specific Comments

CATEGORY	SECTION	COMMENTS
Background & Intent	599.1 (a-e)	It is The Coalition's understanding that Parts 587 and 588 stand in authority along with Part 599 over OMH's licensed clinics. OMH should stipulate in the Guidance document, in detail, specifically which regulations in Parts 587 and 588 to which providers must still adhere. SOMH should be more specific about (e) "respond in a timely and effective manner," since this non-specific requirement will be evaluated in audits. Perhaps the regulations should define a maximum response time frame. Even though, we understand that specificity of response time is defined in other sections of the regulation, it would prevent auditor idiosyncrasy if it were defined in each instance. The Coalition applauds the concept of a clinical home. Language referencing "clinical home" lacks clarity about how this role is defined and the expectations implied. Lack of clarity is a potential audit risk because this leaves interpretation to other auditing bodies. We recommend that SOMH clearly define "clinical home" in the regulations.
Applicability	599.3 (e)	(e) Regulation states that "Programs that provide medical services, other than health monitoring and health screenings, that comprise more than five percent of the total annual visits shall be licensed by DOH. We understand that approval for this requirement is still pending for Article 31 clinics. We are concerned that DOH licensed D & TCs already have the mechanism to provide mental health services, which is unfairly competitive with Article 31 clinics, and impedes realization of the OMH vision of a clinical home.
After Hours	599.4(a)	The after-hours definition should be broadened to increase peak hours of

		demand. Minimally, before 9am or on/and after 5pm should be considered after hours.
Definitions - Clinical Staff	599.4(f)	The term “clinician” is used throughout regulation. Clinical staff should include the term “clinician” in definition of “Clinical Staff”. The current interchangeability of terms is confusing.
Collateral	599.4(g)	The definition of collateral should be expanded to include a fuller understanding of “significant other” to include teachers and other non-life partner individuals who are important to the consumer’s care. There is a discrepancy between the service name and the OMH regulatory name in the description of CPT procedure codes. Of concern is a lack of reference to collateral in the OMH regulatory name.
Complex care management	599.4(j)	Regulations state that complex care management is “an ancillary service to psychotherapy or crisis intervention services.” This service should be an ancillary service to any of the listed services and not limited to psychotherapy and crisis intervention.
Health Monitoring	599.4(s)	OMH needs to provide guidance (cite codes and governing regulations) on how to bill for health monitoring, which is an optional service, especially since Guidance stipulates that these services must be provided by a physician, nurse or other medical professional, which are more expensive that other clinical staff.
Homebound Individuals	599.4 (w)	“The assessment may be made by a “licensed clinician.” A licensed clinical social worker cannot make homebound determinations based on physical illness, because it is outside their scope of practice. The regulations must define homebound. Please clarify if shelters and adult homes are considered a residence for purpose of providing at-home services? The regulations should denote what if any limits there are to types of services that may be delivered in the home.

		For programs currently serving homebound consumers, OMH should define a transitional period to determine if an adult currently receiving these services is still eligible for homebound services under the new regulations. Another possibility is to "grandfather" eligibility for those currently receiving services.
Mental Health screening	599.4(ae)	The section seems to confuse "assessment" with "intervention." OMH should be more explicit about this definition and its applicability. Mental health screenings are not in the official list of services.
Outreach	599.4(ai)	Engagement under the clinical option is not a billable service, yet outreach refers to <u>enhancing the engagement</u> process or <u>reengaging</u> with individuals. Outreach should be redefined to a designation that is billable.
Definitions - Professional Staff - Psychologist	599.4(ao)(4)	Regulations permit master's degrees in clinical psychology for federal, state, county or municipally operated clinics. They should permit master's degrees in clinical psychology for the voluntary clinics as well. These are currently recognized as a professional clinical staff under Part 587 and should remain so. School psychologists should also be permitted to offer professional psychology services.
Certification	599.5	(c) The regulation should stipulate whether provider also needs OASAS approval for IDDT programs; (l) specialty clinic - refers to children up to, not including the 19th birthday - yet in 599.1(b) it talks about children age 21 allowed in children's clinic. This inconsistency should be resolved in favor of the higher age.
Organization and Administration	599.6	Requirements for Organization and Administration in the OMH Guidance should be denoted in the Regulations, especially with respect to policies and procedures # 1 through # 7. (b) The language should be clarified by restating as "no person shall serve <u>both</u> as a member of the governing body and of the paid staff…….without prior approval….

		(c)(7)(viii) Regulations should stipulate what are the applicable Federal and State laws and regulations regarding the prescription and administration of medications.
Policies and Procedures	599.6(c)(7)	(i) One of the former COPS requirements that are continued in these regulations is that "admission policies must include a mechanism for screening individuals at the time of referral and assuring that those referred from inpatient, forensic, or emergency settings, those determined to be at high risk, and those determined to be in urgent need by the Director of Community Services receive initial assessment services within five business days." While we find this requirement to be laudable and reflective of good standards of care, it practically is often impossible to achieve, because voluntary providers lack control over how the referring organizations discharge their consumers and frequently lack a "warm handover," enabling some consumers to be lost to care. Also, referring providers frequently offer inadequate lead time in order to fulfill this requirement. <u>The Director of Community Services should be made responsible for coordinating the timely discharges and referrals of high need consumers.</u> (iii) Engagement and re-engagement are NOT allowable under the Medicaid clinic option; and we still lack Federal approval for "outreach." <u>These terms should be changed or the requirements should be eliminated in current regulations and amended at a later date</u>. (vi) "Reasonable effort" should be defined and made explicit for auditing purposes. It is also necessary to define "prior recent episodes." (vii) "Ensuring enrollment" language imposes an unfunded mandate upon programs. Deficit funding should be provided to pay entitlement specialists, perhaps employing trained peer specialists.
Restraint and seclusion	599.6(h)(i)	SOMH should tailor the phrase "for any purpose" to allow appropriate provider action, without incurring subsequent sanctions, that would address imminent or immediate threat to physical safety of the consumer, the staff and others until enforcement personnel or emergency help arrives.

Optional Services	599.8	We still await Federal approval in order to bill for outreach. (b)(7) The goal of psychotherapy services should not be defined in regulation. The intent of psychotherapy services is to achieve person-centered treatment goals, as defined by the consumer with his/her clinician and or treatment team.
Allowable Staff	599.9 (b)	We object to the Guidance that states: "by the end of transition year one, all services billed to the uncompensated care pool (except Outreach) must be provided by appropriately licensed staff and by the end of transition year three, all clinic services (except outreach) must be provided by appropriately licensed staff." If there is a four year exemption, SOMH should adhere to the full four years in order to permit staff to obtain the appropriate experience.
Treatment Plan Reviews	599.10 (i)	The current regulation reads; "Treatment plans shall occur no less frequently than every 90 days, or the next scheduled service, whichever shall be later." This wording is unclear and open to differing interpretations. It should state that treatment plans shall occur <u>at least</u> every 90 days (at the soonest business day) or the next <u>provided</u> service, whichever shall be later. We understand treatment planning to be an ongoing process that is based on a client's needs and circumstances. Predicated on these needs and circumstances, treatment plan review should be done, if necessary, prior to the 90 day requirement.
Reviews must include	599.10 (j)	Medicare won't pay for LCSW to sign treatment plan reviews, so change (4) to read signature of the physician, licensed psychologist, or other <u>appropriately</u> licensed individual within ….
Electronic Case Records	599.11(a)(2)	We are pleased that electronic records are acceptable and may be kept in lieu of hard copy.
Discharge Summary	599.11(d)	OMH should define a consolidated record format or preferably adhere to the national standard, Continuing Care Standard (CCD).
Record	599.11(e)	Please clarify the length of record retention for children, which we believe to be

retention		unique.
Record sharing	599.11(f)	HIV and Substance Abuse notes have more stringent requirements for information sharing. Regulations should cite other codes or regulations that govern the sharing of HIV and substance abuse records.

Premises – Controlled access to Meds	599.12(a)(2)	Regulations should cite specific laws and regulations that govern controlled access to and maintenance of medications.
Reimbursement	599.13	599.13 should be written as a separate operations manual.
Modifiers	599.13(b)	The "modifiers" are not really modifiers in CPT language, rather additional CPT/HCPCS codes. Regulations should use other language so as not to confuse the payer.
Peer Groups	599.13(c)	"Base fees will be reduced by 25% during a period in which a provider retains an operating certificate with duration of less than 6 months." Since extensions are sometimes issued for less than 6 months for administrative reasons, the reduction is punitive and should be eliminated or defined more specifically.
Peer Groups	599.13(d)	This language is very open-ended and non-specific. It exposes providers to unpredictable penalties and rate changes. It could be punitive, rather than remedial and should be changed. Furthermore, pay-for-performance is not yet operational and therefore, speculative at this time.
Supplemental Payments for CQI	599.13(l)(1)	We understand that OMH seeks an agreement with providers for payment of CQI supplements with withholds for noncompliance. We call for adherence to such agreements by both parties, government and providers, unless new terms are mutually negotiated for any new agreements. We are concerned with past practice of unilaterally imposed changes/increases in requirements by OMH.
Blended Payments	599.13(m)(3)	The introduction of blended payments is new and complicated. Blended payments should be incorporated into The Coalition's recommended operations manual with specific examples to help providers understand this new methodology.

		(v) "When more than one procedure fee applies to a visit, the applicable discount will be applied solely to the procedure fee component of the reimbursement for such a visit." This statement is unclear and difficult to understand. It will confuse providers and lead to unintentional billing and forecasting mistakes. SOMH should clarify this provision. On OMH-sponsored teleconferences, we have heard that the billing of two legacy services on the same day will result in the second legacy service being paid 25% of the APG rate (for first year) less the 10% discount for the second service. We cannot find this instruction either in regulations or in Guidance. Please clarify.
Transition plan	599.13(m)(6)	The requirement that a transition plan for non-Medicaid services that are funded by COPS be subject to the approval of the Director of Community Services and SOMH is a new level of bureaucracy and burden on providers. It is also confusing, because the non-Medicaid services funded by COPS will be diminishing over four years, as COPS diminishes in the legacy payment, and the standards to which providers will be held is unclear. It is also unclear whether these requirements are equally applicable to COPS I and COPS II providers. This all should be clarified and made explicit. Please clarify whether the LGU is responsible for the audits and plan compliance; whether SOMH is responsible; and whether both branches of government are responsible for audits and plan compliance.
Capital Payments	599.13(7)	All Article 31 clinics, including freestanding ones, should receive parity with Article 28 clinics and also receive a capital payment.
Medical Assistance Billing Standards – Pre-Admission	599.14(b)	OMH should specify how allowed collateral visits are billed. Please specify the appropriate billing codes.
Outreach	599.14(d)(1)	Regulations should provide clearer guidelines to substantiate the authorization of more than 2 procedures.

		If engagement is not reimbursable, it should not be used in the explanation of the outreach service. Is it legal to provide this service only to individuals who are covered by Medicaid fee-for-service and not those who may be covered by Medicaid Managed Care and other insurance?
Initial Assessment	599. 14(d)(2)(i)(a)	The regulations should define homebound status.
Psychiatric Assessment	599.14(d)(2)(ii)(d)	The regulations should clarify whether offsite modifiers are allowed for a psychiatric assessment.
Psychiatric Consultation	599.14(d)(3)(ii)	"Psychiatric Consultation services in excess of one service for the same recipient shall be billed as Consultation." This is an unclear and confusing instruction. It is NOT clarified by the OMH Guidance document. OMH should provide clarification. The Guidance document seems to confuse psychiatric consultation with psychiatric assessment and is overlapping in definitions. It is not clear or explicit how to bill for these services in an Article 31 clinic.
Crisis Intervention	599.14(d)(4)	Please provide clarification on Mobile Crisis Teams and how they interact with clinics which now are providing billable crisis intervention services.
Psychotropic Medication Administration Treatment	599.14(d)(5) and (6)	We applaud the addition of the off-site enhancement to these services.
Psychotherapy Services	599.14 (d)(7)(i)	The bifurcation of psychotherapy services and timeframes here represents a fiscally detrimental departure from current Medicaid requirements of full session and brief sessions. OMH should continue the current Federally approved Medicaid practice of allowing full payment for a 30 minute session.
Developmental / Psychological testing	599.14(d)(8) & (9)	Developmental and psychological testing should be allowed during the initial assessment since it would help determine client suitability for clinic admission criteria. It would also help in determination of appropriate level of care.

Modifiers	599.14(e)(1)	We applaud the fact that these regulations allow for off-site modifiers by a physician or a nurse practitioner in psychiatry.
Concurrency reimbursement	599.14(f)	Please delineate the concurrency regulations for consumers who are enrolled in ACT teams or are being discharged from ACT teams. The rules of billing should be clarified in instances where an individual is enrolled in one program, but appears in crisis at another program. (4) Please provide a definition in regulations of residential health care facility. Clarification is needed about who will bill Medicaid for the initial assessment at a clinic during the transition to service at the clinic. Also, clarification should be made about the rate of reimbursement made to clinics by residential care facilities.
Indigent Care	599.15	(d) Please clarify how the 5% threshold for eligibility will be verified. Regulations, in addition to Guidance, should be clear on these points. (g) This reads as an overly vague requirement creating provider audit risk. OMH should be more explicit about what represents “reasonable efforts” to “maintain financial support from community and public funding sources” and “reasonable efforts to collect payments?” (h) The indigent care pool payment methodology should be clearly defined in the regulations. (i) This is an unacceptable interference in the management of providers who are required by their governing boards to balance their budgets. Provision of services to uninsured individuals is only reimbursed upon proof of service delivery. The amount of reimbursement is variable, dependant on the size of the uncompensated care pool and the number of claims submitted to it, never exceeding 50 cents on the dollar. The amount of such services delivered should be a management decision within parameters suggested by fiscal prudence.