Part 599 – Clinic Treatment Programs
Review of 2nd Draft Regulations
November 5, 2009

General Comments

1) Despite an understanding by stakeholders that the new regulations would be simple and provide burden relief, a review of both draft regulations 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 should be written as an operations manual,** hopefully making the sections clearer and more understandable. In addition, we have the following concerns:

    - Given the complexity of the regulations, and many issues still not clear, (e.g. reimbursement for making homebound visits to several residents in a single apartment building), software companies will have an extremely difficult time making necessary edits.
    - In order to project budget revenues, providers will be forced to purchase the 3M APG software. That is the only way they will be able to shadow bill and verify true reimbursement.
    - 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.

    Examples of increases in unfunded regulatory burden:

    - Increased risk assessments, wellness screenings, etc.
    - Requirement to ensure enrollment of eligible uninsured clients in Medicare or Medicaid
    - All new IT demands (unfunded) for billing APGs, modifiers, checking addresses of consumers to prevent multiple off-site bills at same location, etc.
    - Ambiguous “clinical home” designation
    - Perpetuation of COPS-like expectations for expedited outreach and admission for clients without any corresponding supplemental payments for this work.

2) 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.

3) OMH should offer a subsidy/pass through for the extensive technology changes (hardware and software) engendered by these new regulations.

4) OMH should develop transition plans/templates and offer a hold harmless 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.

New October 15, 2009 draft regulations:

Burden relief attempts in the first draft were removed as unmanageable and not allowed: 1) multiple services on one progress note and 2) treatment plan signature allowed by other than a psychiatrist or physician in FFS Medicaid.

SOMH responded to our concerns about:

1) limiting clinic practices to only evidence based. The regulations now have broadened the practices to include "generally accepted and supported by scientific research practices";
2) requiring 100 percent Utilization Review and now have mandated a minimum of 25 percent random sampling;
3) requiring provision of crisis services and having financial and legal responsibility for clients who have not been in a providers program for up to 2 years. Providers will now be required to provide crisis intervention services after hours – only. No more financial and legal responsibility;
4) the 5% minimum for qualifying for the indigent care pool for providers with multiple clinics was clarified as the minimum of total clinic visits;
5) inconsistent language regarding who can determine homebound status was clarified by designating authority to licensed clinicians.

The following are our comments and explanations about changes from the first set of draft regulations to the second. The fourth column in the chart below describes the changes, or lack thereof, made in the second draft as well as our commentary in red. Comments in green are new clarifications made by OMH staff at the recent 11/3 & 11/4/09 OMH trainings in NYC.

As you know from our one pager we still have major concerns about the entire reform process. In particular are issues with Medicaid managed care and private insurance rates and workforce losses. The new regulations raise some additional concerns: the potential of less than one year for the 75% COPS payments, continuing unhappiness with OMH not having done a stress test, and the lack of parity in rates between peer groups. If OMH wants to fund non-Medicaid services, we believe it should be done with local assistance dollars.

Draft 599 Clinic Regulations
Crosswalk of Coalition Comments v9.24.09
and Revised v10.15.09

CATEGORY	SECTION v9.24.09	COALITION COMMENTS 10.30.09	DRAFT CHANGES & ADDITIONS v10.15.09
Background & Intent	599.1 (a-e)	Are these regulations meant to replace any or all of 587 and/or 588?	599.1(f) & (g) provide some clarity, but still concerned about the possible interpretations of the language: "This Part supersedes inconsistent provisions of Part 587 and 588" in (g).
		(e) "respond in a timely and effective manner" - how will this be evaluated in audit? Perhaps the regulations should define a maximum response time frame? Within 3 business days?	No change
		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.	No change
		The language seems to limit clinic practices only to evidenced-based practices. Is this OMH's intention? Such language may mistakenly give the impression that ALL practice is evidence-based and may lead to reviews of clinics that fault programs not exclusively utilizing evidence-based practice.	599.1(e) Language has been added to include "other practices which are supported by scientific research or generally accepted clinical practice guidelines", which no longer limits practices to evidenced-based only. This is a position sought by the Coalition.
Applicability	599.3 (e)	(e) Programs that provide medical services that	

		comprise more than five percent of the total annual visits shall be licensed by DOH.	
Definitions - After Hours	599.4(a)	Are clinics that are already licensed to provide clinic services 6 days a week eligible for after hours on Saturday? The after-hours definition should be broadened to increase peak hours of demand. Minimally after 5pm should be considered after hours	No change
Definitions - Homebound Individuals	599.4 (u)	"The assessment may be made by a "licensed clinician." Later in Part 599.14 (e) (1), "off-site services modifier is available for an initial assessment to determine if the adult is 'Homebound', as clinically determined by a physician or psychiatric nurse practitioner." The regulations must be consistent about which professionals are permitted to make an assessment about who is "homebound." A licensed clinical social worker cannot make homebound determinations based on physical illness, because it is outside their scope of practice. It would be helpful for the regulations to define homebound. Is a shelter considered a residence?	No change 599.14(e) Language is now consistent; both sections now say licensed clinician. Homebound assessments are now determined by a "licensed clinician" and not physician or psychiatric nurse practitioner. However our concerns about scope of practice still remain. OMH indicates that they are not asking for a diagnosis for a physical "homeboundedness", only an observation of physical causes. A mental health barrier does require a mental health diagnosis. No change
Definitions – New			(aa) has been inserted to define a Local Government Unit

Definitions - New			(af) Outreach and Engagement has been changed to Outreach only. Throughout the revised draft Engagement has been removed from the service of Outreach and Engagement. OMH discussed a certification process for family members and peers who will be doing outreach. OMH is also looking at additional peer provided services which could be reimbursed by Medicaid.
Definitions - Clinical Staff	599.4(e)	The term "clinician" is used throughout regulation. Clinical staff should include term clinician in definition of "Clinical Staff".	No change
Definitions - Professional Staff - Psychologist	599.4(ak)(10)	Why are master's degrees in clinical psychology being allowed "for federal, state, county or municipally operated clinics," but eliminated for voluntary providers? These are currently recognized as a professional clinical staff under Part 587 and should remain so.	599.4(al)(4) This was not addressed even though the word 'Licensed" was inserted before Psychologist.
Definitions - Professional Staff - Psychologist	599.4(ak)		The order of all professional staffing was changed. 599.4(al)(3)Licensed was added before Psychoanalyst. 599.4(al)(7) & (7) It's a bit unclear, but it looks like they've added Nurse Practitioner in addition to a Nurse Practitioner in psychiatry. 599.9 Staffing - also now lists them both.

			599.4(av) Visit now has a broader definition it "means an interaction consisting of one or more…" replacing the more narrow: "a mental health clinic visit consisting of one or more …
Certification	599.5		599.5(l) Designated licensed specialty children's services are authorized to provide clinic treatment to children "up to but not including their 19th birthday".
Organization and Administration	599.6	The draft regulations confuse management responsibilities and governance responsibilities throughout this section. (c) It will be difficult to recruit and retain Board members with the lengthy and complex responsibilities assigned to them.	No change
Utilization Review	599.6(l)	We strenuously object to these sections, especially to the utilization review of a Clinic Restructuring (l) effort as a vehicle to impose new and onerous regulations. These include the new regulations applying to Boards (c) as well as the risk management program (j).	599.6(l) In the second sentence, referring to utilization reviews (UR), the phrase "**at a minimum, on a random 25 percent sample of recipients**" was inserted to quantify the number of URs expected. Previous language required 100% UR. This is a very welcomed change. 599.6(j) No change
Policies and Procedures	599.6 (7)	(i) and (ii) These regulations perpetuate and actually increase COPS-like responsibilities of providers in the absence of COPS reimbursement. Guidance documents should be specific about risk assessments needed and careful to minimize unnecessary paperwork. (vii) "ensuring enrollment" language imposes an	No change – this continues a pattern of burdensome mandates. There has been no regulatory relief as promised by the state.

		unfunded mandate upon programs and furthermore doesn't acknowledge the consumer's right to elect or not elect government-sponsored insurance.	
Required Services – Assessment Services	599.8(b)		This section has been removed and the language pertaining to health screening and reports from recipients primary care physician have been included in 599.8(b)(2)
Required Services – Initial Assessment			599.8(b)(2) Initial Assessment now includes health screening and is no longer limited to just mental health. Health screening documentation may be obtained from other sources.
Required Services	599.8 (c)(4)	This definition shifts all the financial and legal liability to the previous provider for clients that may have been discharged and admitted to other program [see 599.14(d)(4)(i)]. In addition, if the client is a patient of another program, the provider	Now 599.8(b)(4) **All language referring to patient responsibility for 2 years has been removed.** It now says "After hours coverage shall include, at a minimum the ability to provide brief crisis intervention services…" It also says that the nature of the crisis and measures taken should be reported to the primary clinician at the health clinic "or the individual's primary care or mental health care provider, if known". OMH is still working on the crisis intervention service so regulations may change again. Go to section 599.14(d)(4)(i) for changes related to this comment

		who helps with the crisis cannot bill for the service. This is a confusing and unreasonable set of cross obligations that should be clarified.	
Optional Services	599.8 (d) (3) and (4)	These services (health physicals and wellness screening) should similarly be carved out of managed care Medicaid for any clients receiving the mental health SED/SPMI carve-out thereby permitting clinics to bill for these services.	No change, now 599.8(c) (3) & (4) Physical exams and wellness screenings can be done in MH clinics without a referral from a managed care organization. Medicaid will pay and track the services as mental health type services.
Clinics Approved as Child & Family Clinic Plus	599.8 (e)	Will the supplemental funding be continued for Child and Family Clinic Plus? Are quarterly statistics still required? Will supplements be provided for non-Medicaid clients in re: assessments and home visits?	No change, now 599.8(d)
Staffing	599.9 (a)	"Adequate and appropriate mix of staff" is too vague and opens providers up to auditors' eccentric interpretations. Minimum time requirements should be set. These requirements should be based on numbers of clients served. By omitting requirements for minimum numbers of full time staff, this regulation encourages agencies to hire hourly workers in order to meet unclear time standards and to lower staff costs.	No change
Allowable Staff	599.9 (b)	A caveat should be added to reflect the possibility that the extension of the mental health license exemption will expire in July 2010. That would change standards and narrow the supply of eligible staff.	No change regarding licensure. Subsection numbering changed. Added: (2) Family advisors, (7) Nurse practitioners in psychiatry Changed: (8) Peers is now Peer advocates OMH indicated that should an extension to the licensing law be granted they would "phase-in" licensure requirements to match

			financial transition: By the end of year one – uncompensated care pool clinic services (except Outreach) must be provided by appropriately licensed staff. – this was a negotiated agreement with DOH. By the end of year three – all clinic services (except Outreach) must be provided by appropriately licensed staff. We are not pleased with these restrictions.
Criminal Background checks	599.9(c)		It now specifies that all clinic staff of "providers licensed solely under Article 31 of the Mental Hygiene Law" shall submit to background checks.
Plan Signatures	599.10 (c-e)	(c-d) Dual eligible consumers will require physician signature regardless of treatment modality. The federal health care system considers this "health care," follows a medical model and requires the physician's signature. (See State Medicaid manual §4421.) This may increase paybacks by providers or reduce the FFP. (e) Where must the recipient's/guardian's signature be documented?	(c-d) No change Added (e) **Treatment plans for Medicaid FFS must be signed by psychiatrist or physician only.** Sections c & d were attempts to provide some signatory relief but are not allowed under Medicaid. Now (f) - No change
Treatment Plan Completion	599.10 (f)	Requiring completion of a treatment plan prior to a second visit after admission is rarely feasible and therefore unacceptable. The treatment plan is person centered and may include collaterals, both of which may delay rapid completion. The requirement should be based on visits only and not on time frame. This would be simpler for	Now (g) Confusing wording about treatment plan completion prior to second visit after admission or 30 days after admission has been removed. **Now it only says "not later than 30 days after admission".**

		IT and staff tracking. Furthermore, if a recipient should not show up at the clinic for 30 days, the plan would have to be completed in the recipient's absence.	
Progress Notes	599.10 (j)	We acknowledge that OMH is trying to simplify paper work by allowing a single progress note for multiple services. However, the regulation is very unclear and has major clinical and IT implications. Most payers require notes for each encounter. What about services provided by different providers? Who would have knowledge of both visits and the documentary responsibility? e.g. Doctor provides a med visit in AM and group psychotherapy in the PM. What about same day services covered by different payers (Medicaid for collateral visit with parent and Medicare for visit with a Doctor)?	Now (k) –The language permitting multiple services to be recorded on the same progress note has been removed. Now, each clinician must record progress notes on each occasion of service provision.
Discharge Summary	599.11 (c) and (d)	(c) What, if any, is the responsibility of the receiving agency? What if a recipient is discharged on Friday and starts new program on Monday? (d) OMH should define a consolidated record format	(c) "where applicable" was added after 'discharge summary shall be transmitted to the receiving program'. Otherwise, no change (d) No change
Record retention	599.11 (e)	HIV and Substance Abuse notes have more stringent requirements for information sharing. Need consumer/guardian consent for sharing of information on these conditions.	No change

Reimbursement	599.13	599.13 should be written as an operations manual.	No change – many sections renumber/ordered
Peer Groups	599.13 (d)	This language is very open-ended and non-specific. Exposes providers to unpredictable penalties and rate changes. It is punitive, rather	No change

		than remedial and should be changed.	
Peer Group Base Rates	599.13(h)		599.13(h) Providers licensed solely under Art 31: Upstate - $130.29* **Downstate - $141.62*** LGU-Operated $181.28* *Due to the APG process, a discounting weight of 15% is then imposed on these base rates to lower reimbursement for services. **Base rate for Downstate is actually $120.37**. Separate **and lower** rates were also listed for new clinics or clinics commencing service in a new county for 2010, 2011 and 2012 by peer group. OMH indicated that the rates posted in the regulations are the equivalent of "legacy rates" for existing clinics. These rates will be phased out during the APG transition period in the same way as existing clinics: 75/25, 50/50 and 25/75. The lower rates are equivalent to rates paid to providers elsewhere in the state. 599.13(i) Providers licensed under Art 28 and Art 31 are divided into peer groups and base rates will be calculated pursuant to 10 NYCRR 86. The peer group for counties with populations under 135,000 was eliminated.

System Transition	599.13 (j)	(4)-(6) Blended payment formulas are not transparent. Regulations should provide examples of payment methodology for various typical combinations of same day services: Give examples for: 2 APG procedures; 2 procedures in same APG; 2 blended services; 1 blended and 1 procedure	Now 599.13(k) 599.13(k)(1)&(2)(ii) Supplemental payments under Part 592 (COPS) will be identified for the extended period of 7/1/2008 to 6/30/2009. Previously the time period was the last 6 months of calendar 2008. (4) is now 599.13(k)(3)&(4) 599.13(k)(3) **For providers solely licensed as Art 31, the first transition year begins sometime in 2010 but ends 12/31/2010**. **This, in effect, reduces the time period for the blended rate with 75% COPS to less than one year.** OMH reported that they want each transition year to be a full year, so we'll wait and see if these change. Year 1 – Services provided on or before December 31, 2010 Year 2 – Services provided on or after January 2, 2011 and including December 31, 2011 Year3 – Services provided on or after January 1, 2012 up to and including December 31, 2012. 599.13(k)(4) Co-licensed Art 28 & Art 31 will follow transition schedule described in 10 NYCRR part 86.

			(6) is now 599.13(k)(1)(v) – No change
		Change in medication treatment service reimbursement represents significant provider losses of revenue immediately, because there is no phase-out of COPS but rather an immediate elimination.	No change
		This methodology will have a disproportionate revenue impact on children's providers (e.g. same day child visit & collateral visit) where there is the standard practice of delivering individual and collateral visits on the same day. Present billing allows COPS to be paid on both services, so it is unclear why the legacy payment for collateral visits must be immediately discontinued for collaterals as a second service in order to minimize additional COPS payments. This change represents a large loss for many children's providers in the first year of implementation.	No change
Transition plan	599.13(j)(8)	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. This comment refers also to the requirement in 599.14 (d) (4) (i) that requires contracts be approved by LGU for crisis services.	Now 599.13(k)(5) – No change No change
Capital Payments	599.13(j)(9)	Article 31 clinics should receive parity with Article 28 clinics and also receive a capital payment.	Now 599.13(k)(6) – No change
Medical Assistance Billing Standards –	599.14(b)	Confirm that total number allowed for children – is it 6, (3 for recipient pre-admission visits and 3 pre-admission visits for collateral)?	**Only three Pre-admission visits are allowed.** The mention of "and 3 pre-admission collateral visits" has been removed. Pre-admissions visits

Pre-Admission		Is the allowed collateral billed as code 90801, 90846, or 90847? We need written guidance concerning correct codes for such visits.	allowable has been changed to "up to three pre-admission visits. **Each visit may include an individual service, a collateral service, or both**." No change
Outreach and Engagement	599.14(d)(1)	Regulations should provide clearer guidelines to substantiate the authorization of more than 2 procedures to an individual.	The words "and engagement" have been removed. Otherwise, no change.
Assessment Services			599.14(d)(2) A new sentence has been added at the end of the paragraph: "For recipients previously served by the clinic, additional pre-admission assessments procedures shall not be eligible for Medicaid reimbursement if less than 365 days have transpired since the most recent Medicaid reimbursed visit to the clinic."
Initial Assessment	599. 14(d)(2)(i)(a)	Definition of criteria for homebound status would be helpful.	No change
Offsite Assessment and Psychotropic Medication Treatment	599.14 (d) (2) (ii) (d) and 599.14 (d) (6)	The lack of offsite payment is problematic for some geriatric or homebound consumers in need of these services.	No change
Crisis Intervention	599.14(d)(4)	The assignment of <u>all</u> legal and fiscal liability to the clinic for providing crisis services is onerous and potentially destructive to the clinic.	In section (4)(i) the 2 year financial and legal liability requirement has been removed and replaced with: "Clinics will be permitted to bill for individuals who have not engaged in services for a period of up to 2 years". **This is a**

		If the recipient is enrolled in another program or has been enrolled in other programs within the elapsed two years, who is responsible for crisis intervention for that recipient? What if insurance coverage has changed? What about recipients who have moved out of the providers service area? This regulation as written assumes that clinics respond and operate as if they had crisis teams, which they are neither staffed nor funded to maintain. How does a mobile crisis team fit in to this regulatory requirement?	**major relief for providers** but doesn't address the issue of billing when the individual may be currently enrolled in another Medicaid program. OMH is still working on the crisis intervention service so the regulations may change again. No change
Psychotropic Medication Treatment			599.14(d)(6) A 15 minute minimum duration of the face-to-face contact has been added. "Physician or nurse practitioner in psychiatry" has replaced clinicians.
Psychotherapy Services	599.14 (d) (7) (i)	The timeframes here represent an unhelpful departure from current Medicaid requirements of full session and brief sessions. We continue to believe that the current Medicaid standards should be preserved in the new regulations.	No change
Developmental / Psychological testing	599.14(d)(12-13)	The regulations should be clear on whether these can be administered during the initial assessment?	No change
Modifiers			599.14(e) In addition to billing modifiers, "modifiers paid as

			supplementary rates to visits" was added. We're not sure of the implications of this. **Homebound assessments are now determined by a "licensed clinician" and not physician or psychiatric nurse practitioner.** There is still a scope of practice issue with MH clinicians determining a physical cause for homebound status. OMH indicates that they are not asking for a diagnosis, only an observation of physical "homeboundness".
Cross reimbursement	599.14(f)	Regulation should be specific on the number of allowable co-enrolled session for clients transitioning from ACT. 3 pre-admission sessions are too limited considering history of non-compliance with treatment – Recommendation: 6. This regulation should allow crisis visits to be billed by a provider (even if a client is enrolled at another Medicaid program) if there remains any responsibility for a prior treatment source to deliver crisis services for someone post-discharge. (4) What is the definition of residential health care facility? How does this prohibition impact initial assessment at a clinic when a client will be transitioning to service at the clinic?	No change No change
Indigent Care	599.15	(d) Will the 5% minimum be calculated per clinic or an aggregate of all clinics under a provider umbrella? How will the 5% be verified?	For agencies with **multiple clinics**, eligibility for the indigent care pool will be determined by a **minimum of 5% of**

		Regulations should be clear on these points.	**the total clinic visits** which meet the requirements.
		599.15 (h) The indigent care pool payment methodology should be clearly defined in the regulations.	No change
		599.15 (g) This reads as an overly vague requirement creating provider audit risk. What represents “reasonable efforts” to “maintain financial support from community and public funding sources” and “reasonable efforts to collect payments?”	No change
		599.15 (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. The amount of such services delivered should be a management decision within parameters suggested by fiscal prudence.	No change