



**Department
of Health**

Office of
Health Insurance
Programs

NEW YORK STATE

ACCESS MONITORING REVIEW PLAN

2016

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I. Access Monitoring Review Plan Overview

The New York State Department of Health is the single state agency federally designated to have oversight of the Medicaid program. The Office of Health Insurance Programs within the Department of Health is responsible for administering the Medicaid program.

New York State is the fourth most populous state with a total population of 19.8 million. Approximately 6.3 million individuals, or 32.2 % of New York's population, are enrolled in the New York State Medicaid program.

In accordance with 42 CFR 447.203, New York State developed an access and monitoring review plan (AMRP) for the following services (AMRP services) provided under a Medicaid fee-for-service (FFS) arrangement:

- Primary care services;
- Physician specialist services;
- Behavioral health services;
- Pre- and post-natal obstetric services, including labor and delivery; and
- Home health services.

The AMRP provides information and data that will be used to measure access to care for the AMRP services for members in FFS Medicaid. The plan considers:

- The availability of Medicaid providers;
- Utilization of Medicaid services; and
- The extent to which Medicaid members' healthcare needs are fully met.

The plan was developed during 2016 and posted on New York State's Department of Health website to allow for public inspection and feedback.

II. New York State's Medicaid Program

The New York State Department of Health (DOH) is the single State agency responsible for the administration of the New York State Medicaid Program under Title XIX of the Social Security Act. The primary purpose of the Medicaid Program (Program) is to make covered healthcare services available to eligible individuals.

As the single State agency, DOH promulgates all necessary regulations and guidelines for Program administration, develops professional standards for the Program, develops rates and fees for medical services, performs hospital utilization reviews, and determines adequacy of medical services submitted for Medicaid reimbursement.

Administrative functions include development of Program policy, determination of recipient eligibility, review of ambulatory care utilization, detection of possible fraud and abuse, and supervision of the Fiscal Agent and all its functions.

In order to carry out aspects of the professional administration of the Program, the DOH's Office of Health Insurance Programs (OHIP) works in conjunction with other State agencies including the Office of Mental Health (OMH), Office for People With Developmental Disabilities (OPWDD), Office of Alcohol and Substance Abuse Services (OASAS), and the State Education Department (SED) to ensure that the needs of the special populations served by these agencies are addressed within the parameters of the Medicaid Program.

Nearly all services under the New York State Medicaid program are provided through enrollment in a managed care plan.

III. . Medicaid Redesign Team

To address underlying health care cost and quality issues in New York's Medicaid program, the Medicaid Redesign Team (MRT) was created in 2011, to both craft a first year Medicaid budget proposal as well as develop a multiyear reform plan. Key Medicaid stakeholders were invited to the table in a spirit of collaboration to identify and explore what could be achieved collectively to change course and rein in Medicaid spending, while at the same time improving quality of care.

Medicaid redesign is premised on the idea that the only way to really control costs is to improve the health of program participants. The MRT action plan launched a series of innovative solutions designed to better manage care and reward providers for helping to keep people healthy. New York's approach differs from that of other states, which have relied on taking away benefits from low-income people or cutting provider payment rates as ways to cut Medicaid costs. Medicaid Redesign is not just about cost control – it also focuses on improving quality of care.

More than 200 initiatives were created as a result of MRT. These initiatives are implementing programmatic changes to the way health care is provided, reimbursed and managed to ensure the provision of quality care in the most efficient manner. Three major MRT initiatives include:

- Delivery System Reform Incentive Payment (DSRIP);
- Health Homes; and
- Managed Care Expansions.

Delivery System Reform Incentive Payment (DSRIP)

The DSRIP program addresses critical issues throughout New York State and allows for comprehensive reform. The program will promote community-level collaborations and focus on system reform, with a goal of achieving a 25 percent reduction in avoidable hospital use over five years. Safety net providers will be required to collaborate to implement innovative projects focusing on system transformation, clinical improvement and population health improvement. DSRIP funds are based on performance linked to achievement of project milestones.

In addition, the Special Terms and Conditions of the Medicaid Redesign Team Section 1115 Waiver commit the state to comprehensive payment reform and continuing New York's effort to effectively manage its Medicaid program within the confines of the Medicaid Global Spending Cap.

Health Homes

While the majority of Medicaid enrollees are relatively healthy and only require access to primary care practitioners to obtain episodic and preventive health care, the Medicaid program provides care to several population groups with complex medical, behavioral, and long term care needs that drive a high volume of high cost services including inpatient and long term institutional care.

Navigating the current health care system can be difficult for relatively healthy Medicaid recipients and even more so for enrollees who have high-cost and complex chronic conditions that drive a high volume of high cost inpatient episodes. A significant percentage of Medicaid expenditures are utilized by this subset of the Medicaid population. Appropriately accessing and managing these services, through improved care coordination and service integration, is essential in controlling future health care costs and improving health outcomes for this population.

A Health Home is a care management service model whereby all of an individual's caregivers communicate with one another so that all of a patient's needs are addressed in a comprehensive manner. This is achieved primarily through a "care manager" who oversees and facilitates access to all of the services an individual needs to assure that they receive the services necessary to stay healthy, out of the emergency room and out of the hospital. Under this model, health records are shared among providers so that services are not duplicated or neglected. Health Home services are provided through a network of organizations – providers, health plans and community-based organizations. When all the services are considered collectively they become a virtual "Health Home."

Managed Care Expansions

The New York State Department of Health has established a goal of having virtually all Medicaid enrollees served in care management by 2019. This initiative, designated as *Care Management for All*, began in State Fiscal Year 2011-2012 as a Medicaid Redesign Team (MRT) proposal. The aim of "Care Management for All" is to improve benefit coordination, quality of care, and patient outcomes over the full range of health care, including mental health, substance abuse, developmental disability, and physical health care services. This initiative will also redirect almost all Medicaid spending in the state from fee-for-service Medicaid to a "care management" model under which managed care organizations are paid a capitated rate by the state and are responsible for managing patient care and reimbursing service providers. The care management system in place as of 2016 includes comprehensive mainstream Medicaid managed care plans, HIV/AIDS special needs plans, Health and Recovery Plans providing specialized mental health and substance abuse services, partial capitation long term care plans, "Fully Integrated Duals Advantage" (FIDA) plans for Medicare/Medicaid "dual eligible," and Medicare/Medicaid supplemental plans.

Over the past five years, the majority of benefits and patient populations that were formerly covered by Medicaid fee-for-service have moved into managed care. This

movement to managed care will continue into 2019 and will ultimately help New York State achieve the “Triple Aim” of 1) improving care, 2) improving health and 3) reducing per capita costs.

Certain benefits were formerly carved out of the Medicaid managed care benefit package and Medicaid managed care enrollees received these benefits through the Medicaid fee-for-service system. In addition, the Medicaid Program is continuing to transition additional benefits and populations to managed care. The tables below list the actual or anticipated date of the transition of benefits and populations from Medicaid fee-for-service to Medicaid managed care:

Benefit	Transition Date
Personal Care Services	August 1, 2011
Pharmacy	October 1, 2011
Personal Emergency Response System (PERS)	January 1, 2012
Dental (for counties where Managed Care Plans were not already covering dental as an optional plan-covered benefit)	July 1, 2012
Orthodontia (for children with severe handicapping malocclusions)	October 1, 2012
Consumer Directed Personal Assistance Services	November 1, 2012
Medical Social Services (MSS) and Home Delivered Meals for individuals formerly enrolled in the Long Term Home Health Care Program (LTHHCP) who transitioned to Medicaid Managed Care	April 1, 2013
Adult Day Health Care and AIDS Adult Day Health Care	August 1, 2013
Tuberculosis Directly Observed Therapy	August 1, 2013
Hospice	October 1, 2013
HIV Genotypic and Phenotypic Drug Resistance Tests and Viral Tropism (Trofile) Assay	April 1, 2014
Comprehensive Medicaid Case Management	January 1, 2015
HIV COBRA	January 1, 2015
Residential Health Care Facility (Nursing Home) Services – Long Term Placement	Beginning February 1, 2015, following a geographic phase-in schedule
Behavioral Health (Previously Carved Out OASAS and OMH Services for Adults - New York City)	October 1, 2015
Injectable Atypical Antipsychotic Drugs for SSI and SSI-related Individuals	October 1, 2015
Behavioral Health Home and Community Based Services for Adults Enrolled in Health and Recovery Plans – New York City	January 1, 2016
Behavioral Health (Previously Carved Out OASAS and OMH Services for Adults – Rest of State)	July 1, 2106

Benefit	Transition Date
Behavioral Health Home and Community Based Services for Adults Enrolled in Health and Recovery Plans – Rest of State	October 1, 2016
Hemophilia Blood Factors	April 1, 2017
Assisted Living Program	April 1, 2017
Indian/Tribal Provider Services (Tribal Providers and Referral Services When Non-Participating)	July 1, 2017
School Based Health Center Services (SBHC)	July 1, 2017
Behavioral Health (Previously Carved Out OASAS and OMH Services for Children - New York City, Nassau, Suffolk, Westchester)	July 1, 2017
Behavioral Health (Previously Carved Out OASAS and OMH Services for Children – Rest of State)	January 1, 2018

Population	Transition Date
Restricted Recipient Program Individuals	August 1, 2011
Individuals with a Relationship with a Primary Care Provider Not Participating in Any Managed Care Plan	October 1, 2011
Individuals Living with HIV (Upstate)	October 1, 2011
Individuals Without a Choice of Primary Care Provider Within 30 Miles/30 Minutes	October 1, 2011
Non-SSI SPMI Adults and Non-SSI SED Children	October 1, 2011
Individuals Temporarily Living Outside of Their Home District	October 1, 2011
Pregnant Women with Prenatal Provider Not Participating in Any Managed Care Plan	October 1, 2011
Persons Receiving Mental Health Family Care	October 1, 2011
Individuals Who Cannot Be Served Due to a Language Barrier	October 1, 2011
Individuals with End Stage Renal Disease	April 1, 2012
Individuals Receiving Services Through the Chronic Illness Demonstration Program	April 1, 2012
Homeless Persons (Non Duals)	April 1, 2012
Infants Born Weighing Less the 1,200 Grams or Disabled Under 6 Months of Age	April 1, 2012
Individuals with characteristics and needs similar to those receiving services through a Home and Community Based Services (HCBS)/Traumatic Brain Injury (TBI) Waiver Program, HCBS/Care at Home (CAH) Waiver Program, Long Term Home Health Care Program (LTHHCP), or Intermediate Care Facility for the Developmentally Disabled	September 1, 2012
Individuals Receiving Consumer Directed Personal Assistance Services	November 1, 2012
Individuals enrolled in the Long Term Home Health Care Program (LTHHCP). [This population may opt out of Mainstream Managed Care and enroll in the Managed Long Term Care program (if program eligible).]	April 1, 2013
Medicaid Buy-In for the Working Disabled (No Premium and Premium Pay)	April 1, 2013
Non-agency Foster Care Children Living in the Community Placed by LDSS (Upstate Only)	April 1, 2013
Nursing Home) - Adults New to Medicaid or Already Enrolled in a Managed Care Plan.	Beginning February 1, 2015, following a geographic phase-in schedule
OPWDD Phase 1 (Voluntary) Dual to OPWDD-FIDA (NYC, Nassau, Suffolk, Westchester, Rockland)	April 1, 2016
Nursing Home (New Dual and Non-Dual Children – Statewide)	April 1, 2017

Population	Transition Date
Assisted Living Program Residents – Non Duals and Duals	April 1, 2017
Bridges to Health (B2H) – All Categories – Non Duals (New York City, Nassau, Suffolk)	July 1, 2017
HCBS Care at Home Waivers 1 and 2 – Duals and Non Duals (New York City, Nassau, Suffolk)	July 1, 2017
Agency Based Foster Care Children – Non Duals (New York City, Nassau, Suffolk)	July 1, 2017
Prenatal Care Only (Partial Eligibility During Presumptive Eligibility Period)	December 1, 2017
Individuals with Returned Mandatory Mailings	December 1, 2017
Spend Downs	December 1, 2017
Comprehensive Third Party Health Insurance	December 1, 2017
Individuals Residing Out of State	December 1, 2017
Cancer Treatment Program (Partial Eligibility)	December 1, 2017
HCBS Waiver – Nursing Home Transition and Diversion (NHTD)	January 1, 2018
HCBS Waiver – Traumatic Brain Injury (TBI)	January 1, 2018
Well Duals	January 1, 2018
Bridges to Health (B2H) – All Categories – Non Duals (Rest of State)	January 1, 2018
HCBS Care at Home Waivers 1 and 2 – Duals and Non Duals (Rest of State)	January 1, 2018
Agency Based Foster Care Children – Non Duals (Rest of State)	January 1, 2018
HCBS Care at Home Waivers 3, 4 and 6 –Non Duals (New York City, Nassau, Suffolk)	October 1, 2019
HCBS Care at Home Waivers 3, 4 and 6 –Non Duals (Rest of State)	October 1, 2019

IV. Member Population

All New Yorkers: Medicaid and Non-Medicaid by Gender and Age

	NEW YORKERS WITH MEDICAID ¹	%	NEW YORKERS WITHOUT MEDICAID ²	%	ALL NEW YORKERS ³
POPULATION	5,837,472		13,908,755		19,746,227
Gender					
Male	2,617,099	45%	6,964,162	50%	9,581,261
Female	3,220,373	55%	6,944,593	50%	10,164,966
Age					
0 - 4	665,893	11%	518,698	4%	1,184,591
5 - 9	553,276	9%	1,510,259	4%	1,140,163
10 - 19	926,208	16%	9,029,276	11%	2,436,467
20 - 64	3,057,636	52%	12,086,912	65%	12,086,912
65 +	634,459	11%	2,898,094	16%	2,898,094

1. Medicaid Members:
 - a) Medicaid monthly enrollment for July 2014.
 - b) Age as of July 2014.
2. Non-Medicaid: calculated as: All New Yorkers # - Medicaid Members #
3. All New Yorkers:

Vital Statistics of New York State 2014

https://www.health.ny.gov/statistics/vital_statistics/

U.S. Census Bureau, 2014 American Community Survey 1-Year July 1 2014 Estimate

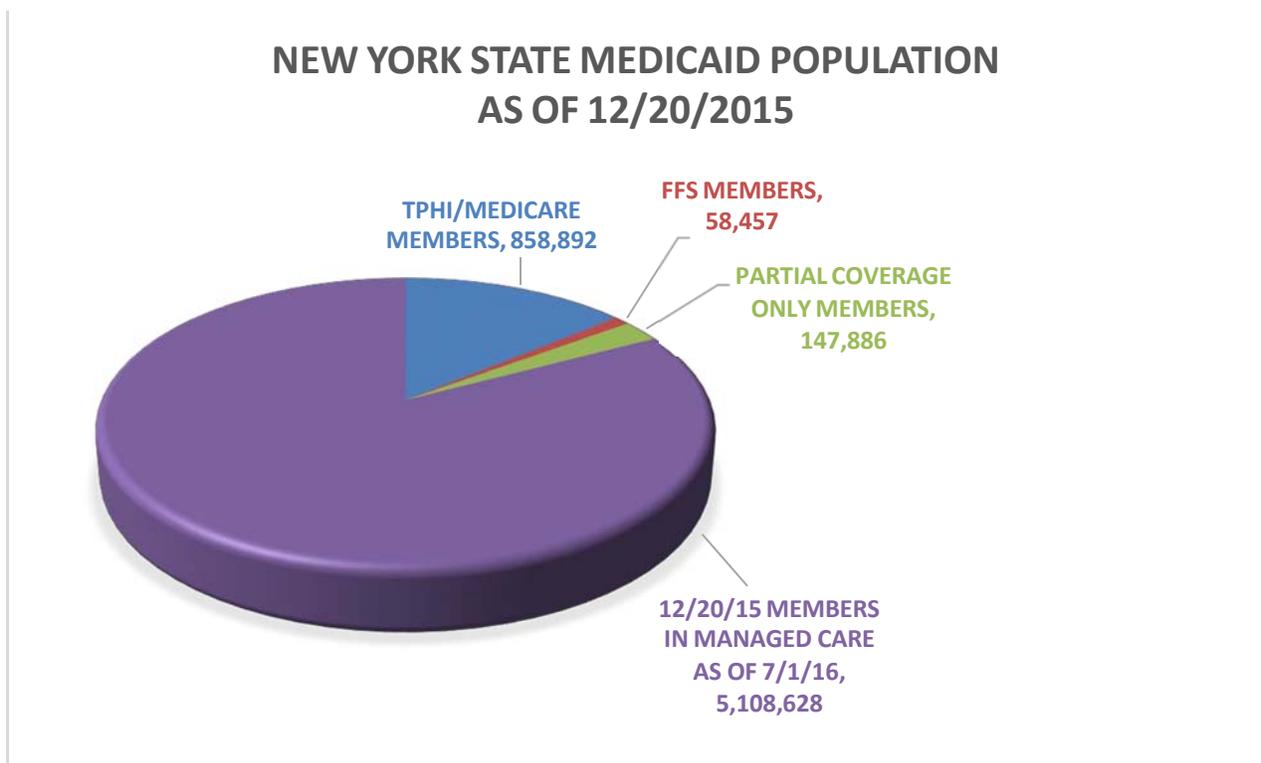
The *All New Yorkers: Medicaid and Non-Medicaid by Gender and Age* chart uses statistics from July 2014. However, as of December 20, 2015, New York State Medicaid enrollees totaled 6.3 million members. Most New York State Medicaid members are enrolled in a Medicaid managed care plan.

New York State Medicaid Population as of December 20, 2015

As of December 20, 2015, only 1,521,064 of New York's 6.3 million Medicaid members, were not enrolled in a Medicaid managed care plan. Of the 1,521,064 Medicaid members, 858,882 have either Medicare or other third party health insurance (TPHI). This leaves a total of 662,172 non-Medicare/non-TPHI Medicaid Fee-For-Service (FFS) members - either having Medicaid on 12/20/2015 or receiving Medicaid retro-actively to 12/20/2015. Of the 662,172 non-Medicare/non-TPHI Medicaid FFS members, 329,692 became MMC Enrollees sometime within the next six months.

The pie chart, *New York State Medicaid Population As Of 12/20/2015*, separates the Medicaid members having fee-for-service (FFS) Medicaid from the Medicaid members with managed care, Medicare, TPHI and partial coverage. Partial programs include:

- Family Planning Benefit Program (FPBP),
- Health Insurance Payment Only,
- Inpatient Hospital Only (with FFP), and
- Emergency Services Only.



Important to note: Within a few years, New York State will have achieved statewide managed care enrollment, and the FFS Members category will only contain members having partial coverage and members for which there is no federal financial participation (FFP).

Medicaid Managed Care

As previously stated, New York State's Medicaid program has established a goal of having virtually all Medicaid enrollees served in care management by 2018. As of June 2016, a total of 4,952,493 individuals were enrolled in managed care. New York State has several types of managed care plans providing services to Medicaid eligible individuals as outlined below.

Medicaid Managed Care Plans

Mainstream Medicaid Managed Care (MMC) Plans provide a comprehensive benefit package for individuals with full Medicaid eligibility who are not otherwise excluded from enrollment in Medicaid managed care. The benefit package covers a full range of services, including, but not limited to, inpatient and outpatient services, primary care and preventive services, emergency services, family planning and reproductive health services, physician services, pharmacy and durable medical equipment, laboratory services, radiology, rehabilitation services, home health services, personal care services, hospice, eye care, dental services, mental health and substance use disorder services, renal dialysis, and nursing home services. Enrollment in a Medicaid managed care plan is mandatory statewide for most Medicaid eligible individuals. There still exist some populations that are either exempt from enrollment in Medicaid managed care (these individuals can enroll voluntarily) and some populations that are excluded from enrollment in Medicaid managed care, but as indicated in Section II above, efforts to transition of many of these populations to managed care are underway. There are currently 16 mainstream MMC plans in New York State. June 2016 enrollment in mainstream MMC was 4,428,244.

HIV Special Needs Plans (HIV SNP): The Medicaid Managed Care Act of 1996 established standards and authorization for the creation of fully capitated HIV Special Needs Plans to meet the health, medical and psychosocial needs of Medicaid eligible individuals who are living with HIV or AIDS and their related children. Individuals living with HIV and AIDS who qualify for Medicaid managed care and live in New York City may choose between a regular Medicaid managed care plan or an HIV SNP. The HIV SNPs are an alternative to mainstream Medicaid managed care plans and are required to have a network of experienced HIV service providers, HIV specialist Primary Care Providers, and a comprehensive model of case management. HIV SNP enrollees receive all the same services covered by Medicaid managed care, plus coordinated care from HIV experienced primary care providers and other coordinated special services that are important for people living with HIV/AIDS. HIV SNP enrollees may also qualify for Behavioral Health Home and Community Based Services (BH HCBS). HIV SNPs are also required to promote access to essential support services, such as treatment adherence, housing and nutrition assistance, and to reach multi-cultural/non-English speaking communities. There are currently three HIV SNPs in New York State, in New York City only. June 2016 enrollment in HIV SNPs was 14,400.

Health and Recovery Plans (HARPs): The Medicaid Redesign Team created several work groups to review and provide recommendations in key areas, including behavioral health (BH). As a result of the MRT process, the State submitted an amendment to its current Section 1115 waiver demonstration to enable qualified Managed Care Organizations (MCOs) throughout the State to comprehensively meet the needs of individuals with BH needs. One of the mechanisms for meeting these needs was the creation of a new type of managed care plan, the **Health and Recovery Plan (HARP)**. Individuals age 21 years or older who are enrolled in Medicaid and have select Serious Mental Illness (SMI) and Substance Use Disorder (SUD) diagnoses are eligible to enroll in a HARP. MCOs that are certified by the State as meeting specific HARP qualifications operate the HARP line of business, and HARPs are available to enrollees statewide. Individuals meeting the HARP eligibility criteria who are already enrolled in an HIV Special Needs Plan may remain enrolled in their current plan and receive the enhanced benefits of a HARP. HARPs and HIV SNPs are required to arrange for access to a benefit package of Behavioral Health Home and Community Based Services (BH HCBS) for enrollees who are determined eligible for these services. HARPs and HIV SNPs contract with Health Homes, or other State designated entities, to develop a person-centered care plan and provide care management for all services within the care plan, including the BH HCBS. June 2016 enrollment in HARPs was 38,278.

Managed Long Term Care Plans

Managed long term care (MLTC) plans help people who are chronically ill or have disabilities and who need health and long term care services, such as home care or adult day health care to stay in their homes and communities as long as possible and receive needed services in home and community based settings. The MLTC plans are designed to be person-centered and to integrate services and improve health outcomes for individuals in need of Long Term Services and Supports. All MLTC plans arrange and pay for long term care services, as long as these services are medically necessary.

There are four types of MLTC plans: Partially Capitated, Medicaid Advantage Plus, Program of All Inclusive Care for the Elderly, and Fully Integrated Duals Advantage.

In a **Partially Capitated Plan**, an enrollee receives Medicaid services only. Benefit package services through the Partially Capitated Plan include nursing care, home health aides, therapies in the home and outpatient settings, personal care, adult day health care, social day care, nursing home care, audiology, dental, optometry, podiatry, home delivered meals, personal emergency response system and non-emergency transportation. If the enrollee has Medicare, Medicare services remain fee-for-service. An enrollee must be at least 18 years old to join a Partially Capitated Plan. June 2016 enrollment in Partially Capitated Plans was 154,415.

In a **Medicaid Advantage Plus (MAP) Plan**, an enrollee receives both Medicaid and Medicare services through one plan. The enrollee must use the plan's Medicare product and must choose a primary care physician from the MAP provider network. In

addition to receiving the Medicaid-covered Partially Capitated services, the enrollee receives their Medicare-covered services through the MAP Plan, including physician office visits, specialty care, clinic visits, hospital stays, mental health services, x-ray and radiology services, chiropractic care, Medicare Part D drug benefits and ambulance services. An enrollee must be at least 18 years old to join a MAP plan. June 2016 enrollment in MAP was 5,838.

A Program of All Inclusive Care for the Elderly (PACE) Plan provides the enrollee the same Medicaid and Medicare services through one plan as a MAP does, but the delivery of services is different. PACE health services are provided by a team that includes doctors, nurses, social workers and others. The health care professional team works with the enrollee and family work to develop and update the enrollee's plan of care and program goals and to make health care decisions. An enrollee must be at least 55 years old to join a PACE. June 2016 enrollment in PACE was 5,527.

Fully Integrated Duals Advantage (FIDA) is a demonstration program jointly run by New York State and the federal government to provide better health care for people who have both Medicare and Medicaid. Under this demonstration, the state and federal government are testing new ways to improve how individuals receive their Medicare and Medicaid health care services. At present, this demonstration is scheduled to last until December 31, 2017. FIDA plans serve individuals age 21 years and older who are eligible for both Medicare and Medicaid. The FIDA plans provide and coordinate all Medicare and Medicaid services for their enrollees. FIDA coverage includes services and items currently covered by Medicare, Medicaid, wellness programs and home and community based services. FIDA plan-covered services include primary care, inpatient hospital and outpatient services, prescription drugs, long-term care services, such as nursing services in the home, home health aide services, and personal care services, as well as certain behavioral services. Some FIDA plans provide supplemental benefits. Each FIDA plan enrollee has an interdisciplinary care team that consists of the enrollee's health care and social care specialists, and, if requested, the enrollee's legal representatives and/or relatives/friends. The team develops a care plan and provides ongoing care management. June 2016 enrollment in FIDA was 5,457.

Fully Integrated Duals Advantage for Individuals with Intellectual and Developmental Disabilities (FIDA-IDD) is a demonstration program jointly run by New York State and the federal government to provide better health care for people with intellectual and developmental disabilities, and who have both Medicare and Medicaid. Under this demonstration, the State and federal government are testing new ways to improve delivery of Medicare and Medicaid health care services. FIDA-IDD offers more opportunities for enrollees to direct their own services, be involved in care planning, and live as independently in the community as possible. At present, this demonstration is scheduled to last until December 31, 2020.

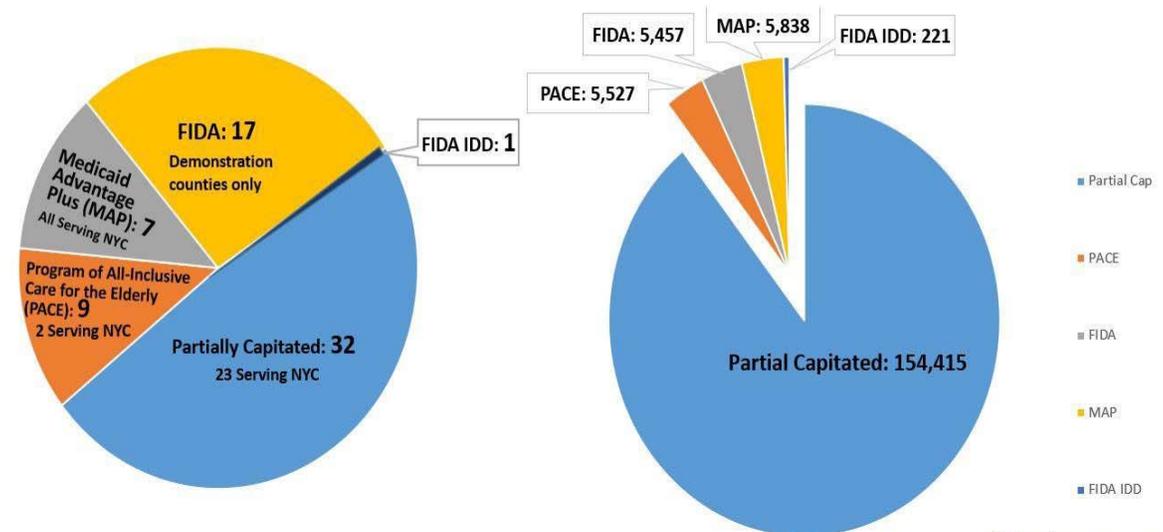
FIDA-IDD plans serve individuals age 21 years and older. The plan is similar to the original FIDA plans (see above) in terms of the benefits package and the model of care. The FIDA-IDD plan covers all Medicare and Medicaid services, including many of the

long-term care services offered through the original FIDA plans and prescription drugs. The plan also offers additional services such as adaptive technology, community habilitation, day treatment, and respite services. Each enrollee has a care team, which is the primary entity responsible for ongoing care management, including authorizing and coordinating covered services. June 2016 enrollment in FIDA-IDD was 221.

MLTC Statewide Enrollment*

Number of Plans Statewide Actively Enrolling: 66

Total Enrollees Statewide: 171,458



*Based on June 2016 Partial/MAP/PACE enrollment reports and the June 2016 FIDA enrollment report



In addition to enrollment in the plans listed above, in June 2016, enrollment in **Child Health Plus** was 291,386 and enrollment in **Medicaid Advantage** was 8,727.

V. Medicaid Eligibility

New York State of Health, the Official Health Plan Marketplace

NY State of Health is an organized marketplace designed to help people shop for and enroll in health insurance coverage. Individuals, families and small businesses can use the Marketplace to help them compare insurance options, calculate costs and select coverage. NY State of Health uses a single application that helps people check their eligibility for health care programs like Medicaid, Child Health Plus, and the new Essential Plan and enroll in these programs if they are eligible. NY State of Health also explains what type of financial assistance is available to applicants to help them afford health insurance purchased through the Marketplace. New Yorkers can complete the NY State of Health application online, in-person, over the phone or by mail.

Local Departments of Social Services

Historically, Local Departments of Social Services (LDSS) were responsible for determinations of Medicaid eligibility. New York is centralizing the Medicaid eligibility process through NY State of Health, starting with the MAGI (Modified Adjusted Gross Income) population. However, LDSS are still responsible for certain populations including individuals who are age 65 years and over and/or in receipt of Medicare (unless a caretaker relative of a child age 18 years or younger), applying for nursing home coverage, Medicaid Waiver Programs for children, Medicaid Buy-In program for Working People With Disabilities, and Medicare Savings Programs. In addition, the LDSS is responsible for some MAGI applicants who have not transitioned to NY State of Health, such as children and pregnant women applying for Medicaid through presumptive eligibility and those applying for the Family Planning Benefit Program. Consumers who apply for health insurance at the LDSS are screened and determined if they are MAGI or Non-MAGI. If they are screened as MAGI, the LDSS forwards the application to NY State of Health.

Categories of Eligibility

There are several different categories of Medicaid eligibility. They can be broken down into MAGI populations and non-MAGI. Categories in the MAGI population include Pregnant women, Infants and Children under 19 years of age, the new Adult Group, parents/caretaker relatives, and consumers enrolled in the Family Planning Benefit Program.

Non-MAGI individuals include SSI recipients, Medically Needy (aged, blind, disabled), ADC-related, Foster Care, Medicaid Buy-In for Working People with Disabilities, Medicaid Cancer Treatment Program, residents of Home for Adults, Medicare Saving Program, individuals applying for Cobra continuation of premium payments and Medicaid Continuation of Pickle, Widow and Widowers and DAC eligible individuals.

Medicaid Eligibility

Until eligibility for the entire Medicaid population can be processed in the Marketplace eligibility system, new applications for the MAGI population will be processed by NY State of Health and new applications for the non-MAGI population will be processed by the LDSS in the Welfare Management System (WMS). The state has worked with the counties to develop a referral process for applications that originate in the wrong place to ensure the eligibility is determined in a correct and timely manner. Individuals applying on the NY State of Health website who indicate certain attributes are referred to the local district to have their eligibility for Medicaid coverage determined using non-MAGI eligibility rules.

Application Process

Most MAGI consumers apply through NY State of Health. Non-MAGI and a few other populations such as presumptive eligibility or Family Planning, apply with their local Department of Social Services.

MAGI consumers may go to the online website at <http://www.healthbenefitexchange.ny.gov/> or seek out assistance through Navigators or Certified Application Counselors at <http://www.healthbenefitexchange.ny.gov/IPANavigatorSiteSchedule>. Managed Care Organizations also help consumers apply. Consumers may also contact NY State of Health directly at (855) 355-5777.

Individuals who apply through the LDSS are screened prior to completing an application. If it is determined the application should be submitted to NY State of Health, and the LDSS is a district with a Certified Application Counselor (CAC) or Navigator on site, they will assist the consumer with completing an application on line for health insurance. If there is no CAC or Navigator available in the district, the LDSS will forward the consumer's application to NY State of Health.

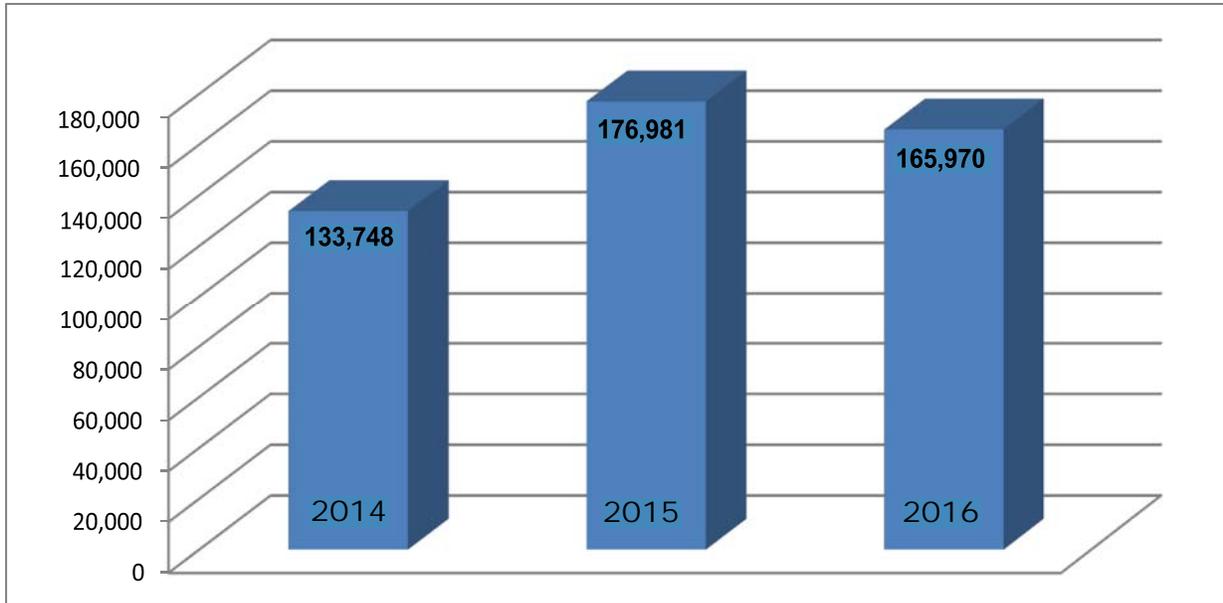
If a household has a combination of MAGI and Non-MAGI consumers, the LDSS will register two separate cases and the two cases will be linked for any under care changes that may be required, by using the "Associated Case" field on WMS.

Consumers applying through NY State of Health or the LDSS who have limited English proficiency may use "I Speak" cards to quickly and easily identify their language. Interpretation services can then be provided by calling Language Line Solutions, Inc. at 1-866-874-7406; Language Line Solutions will assist in the consumer's primary language to provide the consumer access to the programs services and opportunities offered by state government.

VI. Member Call Center

The New York State of Health Call Center receives calls from New Yorkers that are enrolled in one of the State's government sponsored health programs, including Medicaid. The Call Center tracks and monitors all calls.

**NY State of Health Call Center
Average Monthly Call Volume - January 2014 - July 2016**



Calls from Medicaid members make up the largest share of the inbound calls. For a detailed description of call activity, refer to **Attachment #1 – Helpline Data**

Contact information for the Medicaid Helpline is located on the back of the member's Medicaid card - **(800) 541-2831**.



VII. Medicaid Reimbursement

Article 28 Hospital Clinics/Freestanding Clinics

Primary Care Services provided in Article 28 Hospital Clinics or Freestanding Clinics are reimbursed for Medicaid Fee-For-Service based on the Ambulatory Patient Groups (APGs) payment methodology. APGs is a patient classification system designed to detail the amount and type of resources used in an ambulatory visit. Patients in each APG have similar clinical characteristics and resource use and costs. The APG payment methodology was developed by 3M Health Information Systems to encompass the full range of ambulatory settings including same day surgery units, hospital emergency rooms, and outpatient clinics. Three primary types of APGs are significant procedure, medical visit, and ancillary tests & procedures.

- **SIGNIFICANT PROCEDURE:** A procedure which constitutes the reason for the visit and dominates the time and resources expended during the visit. Examples include: excision of skin lesion, stress test, and treating fractured limb.
- **MEDICAL VISIT:** A visit during which a patient receives medical treatment (normally denoted by an Evaluation & Management (E&M) code), but did not have a significant procedure performed. E&M codes are assigned to one of approximately 200 medical visit APGs based on the diagnoses shown on the claim (usually the primary diagnosis).
- **ANCILLARY TESTS AND PROCEDURES:** Tests and procedures ordered by the primary physician to assist in patient diagnosis or treatment. Examples include: immunizations, plain films, and laboratory tests.

The APG payment is calculated by multiplying the APG weight to a base rate which is determined based on the location of the facility (Upstate/Downstate Regions). Additionally, a capital cost component is added per claim. Also, consolidation or bundling, packaging, and discounting logic may apply to calculate the APG final payment.

- **Consolidation (or Bundling):** The inclusion of payment for a related procedure into the payment for a more significant procedure provided during the same visit. CPT codes that group to the same APG are consolidated.
- **Packaging:** The inclusion of payment for related medical visits or ancillary services in the payment for a significant procedure. The majority of "Level 1 Ancillary APGs" are packaged. (i.e. pharmacotherapy, lab and radiology)
- **Discounting:** A discounted payment for an additional, but unrelated, procedure provided during the same visit to acknowledge cost efficiencies. If two CPT

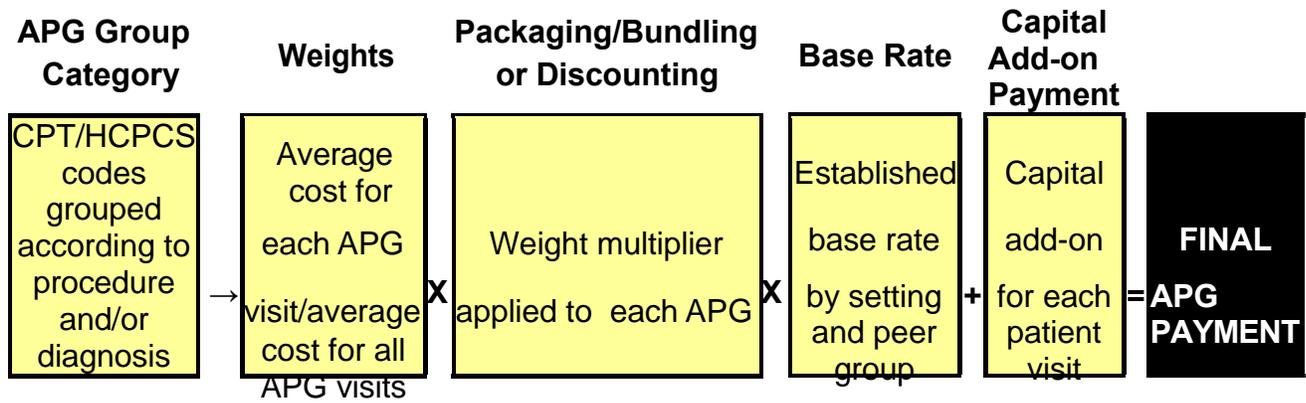
codes group to different APGs, 100% payment will be made for the higher cost APG, and the second procedure will be discounted (generally at 50%).

The base rates were established for peer groups, and the upstate/downstate regions.

- Hospital - OPD, OPD-MR/DD/TBI, SBHC, ED, Amb. Surg.
- Freestanding D&TC – Clinic, Clinic-MR/DD/TBI, SBHC, Renal, Dental Schools and Amb. Surg.
- Downstate - New York City, Nassau, Suffolk, Westchester, Rockland, Putnam, Dutchess, Orange
- Upstate - The rest of the State

The capital rates were calculated and updated every year based on the two year prior cost report except for Ambulatory Surgery centers, which utilized an Upstate or Downstate regional average based on 2005 capital cost reimbursement.

APG PAYMENT CALCULATION OVERVIEW



Weight Multiplier (Consolidating or Discounting Logic)

- 100% for primary (highest-weighted) APG procedure
- 100% unrelated ancillaries
- 150% for bilateral procedures
- 50% for discounted lines (unrelated significant procedures performed in a single visit).
- 0% for bundled/consolidated lines (related ancillaries are included in the APG significant procedure payment)

Example 1. Medical visit

Medical Visit										
CPT Code	CPT Description	APG	APG Description	Payment Element	Payment Action	Full APG Weight	Percent Paid	Allowed APG Weight	Sample Base Rate	Paid Amount
99213	E & M, est. pt., low complexity (15 mins.)	871	Signs Symptoms and Other Factors	Medical Visit	Full Payment	0.6968	100%	0.6968	\$183.53	\$127.88
82565	Creatinine, blood	400	Level I Chemistry Tests	Packaged Ancillary	Packaged	0.1266	0%	0.0000	\$183.53	\$0.00
71020	Radiologic, chest, two views, frontal and lateral	471	Plain Film	Packaged Ancillary	Packaged	0.6717	0%	0.0000	\$183.53	\$0.00
			Operating Totals			1.4951		0.6968		\$127.88
			Capital Add-On							\$72.53
			Total Payment							\$200.41

Primary DX (ICD-10): E0781

Note: All procedures shown were performed on the same date of service, per the APG definition of a visit.

Note: APG weights and base rates shown are for illustrative purposes only.

Example 2. Significant Procedure

Gynecology/Obstetrics Visit										
CPT Code	CPT Description	APG	APG Descp	Payment Element	Payment Action	Full APG Weight	Percent Paid	Allowed APG Weight	Sample Base Rate	Paid Amount
57505	Endocervical curettage	196	Level I Female Reproductive Procd	Significant Procedure	Full payment	5.5356	100%	5.5356	\$183.53	\$1,015.95
87490	Chlamydia trachomatis, direct probe technique	394	Level I Immunology Tests	Packaged Ancillary	Packaged	0.0654	0%	0.0000	\$183.53	\$0.00
87590	Neisseria gonorrhoea, direct probe technique	397	Level II Microbiology Tests	Ancillary	Full payment	0.2393	100%	0.2393	\$183.53	\$38.29
88305	Level IV Surgical pathology, gross and microscopic examination	390	Level I Pathology	Packaged Ancillary	Packaged	0.2324	0%	0.0000	\$183.53	\$0.00
99215	Office or other outpatient visit	491	Medical Visit Indicator	Incidental	Packaged	0.6968	0%	0.0000	\$183.53	\$0.00
			Operating Totals			6.7695		5.7749		\$1,054.23
			Capital Add-On							\$72.53
			Total Payment							\$1,126.76

Note: APG weights and base rates shown are for illustrative purposes only.

Note: APG 397 is Statewide Base Rate APGs. (Statewide Base Price: \$160 as of 1/1/2012)

APG payment methodology was initially approved in the New York State Plan Amendment (SPA) #08-39 for hospital-based outpatient services and #09-01 for freestanding diagnostic and treatment and ambulatory surgery center services.

Additional information on the APG methodology can be found at the Department of Health's APG website:

http://www.health.ny.gov/health_care/medicaid/rates/apg/index.htm.

Federally Qualified Health Centers (FQHCs)

Federally Qualified Health Center (FQHC) is a designation by the Federal Government under Section 330 of the Public Health Service Act PHS. Having an FQHC designation entitles a clinic to enhanced reimbursement from both Medicare and Medicaid.

Unlike other Article 28 clinics, FQHCs are usually paid a prospective payment system (PPS) rate (a threshold rate). They may, however, “opt into” and participate in the APG reimbursement methodology as an "alternative rate setting methodology" as authorized by Public Health Law Section 2807(8)(f).

FQHCs cannot be negatively impacted in their Medicaid reimbursement due to opting into the APG reimbursement methodology. If a facility's Medicaid reimbursement under APGs is lower than what their payment would have been under the federal prospective payment system (PPS) rate, the facility is entitled to receive a supplemental payment reflecting the difference between what they were paid under APGs and what they would have been paid using the PPS rate.

https://www.health.ny.gov/health_care/medicaid/rates/fqhc/

Private Practitioners

New York State Medicaid benchmarks private practicing practitioner fees to a percentage of the Mid-Hudson Medicare fee schedule. For example, physicians receive 60% of the Mid-Hudson Medicare fee schedule.

In addition, Medicaid pays an \$8 add-on for weekend and after-hour appointments in both clinics and office based settings. There is also a 10% payment add-on to the fees paid to office-based physicians in Health Professional Shortage Areas (HPSAs).

VIII. Medicaid Reimbursement Comparison Analysis

Medicare/Medicaid Comparison Analysis

New York State Department of Health (the Department) is currently pursuing the ability to project the Medicare payment for outpatient services utilizing the 3M grouper/pricer for use in future Medicare/Medicaid payment comparisons.

Other Payers/Medicaid Reimbursement Comparison Analysis

The Department is unable to provide a comparison to other commercial/private payers at this time. However, the Department is currently in the process of developing an All Payer Database (APD). New York's All Payer Database (APD) will contain public and private health care claims and encounter data from insurance carriers, health plans, third-party administrators, pharmacy benefit managers, Medicaid and Medicare that can be synthesized to support the management, evaluation, and analysis of the NYS health care system. Payers will provide information about insured individuals, their diagnoses, services received, costs of care, and plan benefits.

Further information on APD can be found at http://www.health.ny.gov/technology/all_payer_database/.

IX. AMRP Service Analysis

Primary Care Services

Primary care is the day-to-day healthcare given by a health care provider. A primary care provider acts as the first contact and principal point of continuing care for patients within a healthcare system, and coordinates other specialist care that the patient may need.

New York State Medicaid qualified primary care providers include:

- Physicians,
- Physician Assistants,
- Nurse Practitioners,
- Physician Specialists, and
- OB/GYN providers.

Primary care providers/services are usually located in:

- Private practice settings,
- Free-standing clinics,
- Federally Qualified Health Centers, and
- Hospital outpatient departments.

New York State has embarked on promoting the Advanced Primary Care (APC) model. The APC is an integrated care delivery and payment model that ties together a service delivery and reimbursement model that promotes improved health and health care outcomes that are financially sustainable.

Advanced Primary Care is a leading model for efficient management and delivery of quality health care services that builds on the principles embodied by the National Committee for Quality Assurance (NCQA) certified medical home. An APC practice utilizes a team approach, with the patient at the center. The care model emphasizes prevention, health information technology, care coordination and shared decision-making among patients and their providers. The APC model is designed to leverage the strengths of New York State's emerging NCQA certified medical homes while laying out a graduated path for all practices to advance toward integrated care.

APC is defined in terms of the following four components:

- A defined set of practice capabilities that promote care coordination for complex patients, support robust connections with the medical neighborhood and community-based services and an administrative infrastructure to be successful in a move from fee-for-service to value-driven, population-based care payment.
- Core measures: Common quality, outcome and cost measures across payers and providers that ensure consistent reporting and incentives.

- Common milestones and measures that define a practice's capabilities over time and that are linked to payment.
- Outcome-based payments: Reimbursement structured to promote and pay for quality and outcomes. APC reimbursement models are designed to support team-based care delivery team (inclusive of physicians, care providers, care managers and others as needed) to promote high quality comprehensive and coordinated care delivery, and provide opportunities for shared savings.

The APC model describes elements of care delivery that have been shown to enhance patient experience and improve clinical care, while also helping clinicians and practices transition to increased value-based payments.

For more information on the Advanced Primary Care model visit the New York State Department of Health website at:

https://www.health.ny.gov/technology/innovation_plan_initiative/docs/advanced_primary_care_fags.pdf

Child/Teen Health Program (C/THP)

Every child deserves to be born well, to be physically fit, and to achieve self-responsibility for good health habits. Every child and adolescent deserves ready access to coordinated and comprehensive, preventive, health-promoting, therapeutic and rehabilitative physical and behavioral health and dental care. Such care is best provided through a continuing relationship with a primary care provider or team, and ready access to secondary and tertiary levels of care.

New York State's Medicaid program for children and adolescents implements Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services via the Child/Teen Health Program (C/THP). In line with the federal EPSDT mandate, C/THP promotes the provision of early and periodic screening services and well care examinations, with diagnosis and treatment of any physical or behavioral health problems identified during these examinations.

SCREENING SERVICES

C/THP requires providers to follow the most current version of the "American Academy of Pediatrics (AAP): Recommendations for Preventive Pediatric Health Care including the AAP Periodicity Schedule and the Schedule of Screenings and Assessments for Well-Child Visits."

DIAGNOSIS

When a screening examination indicates the need for further evaluation of an individual's health, diagnostic services or referral when appropriate should be provided. Any necessary referrals and follow-up should be made without delay to make sure that the child/adolescent receives a complete diagnostic evaluation.

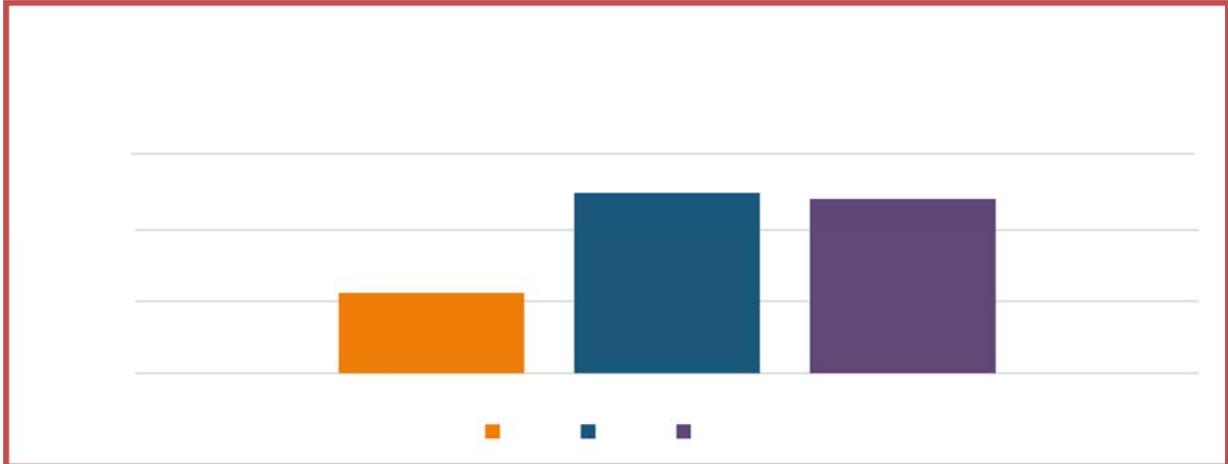
TREATMENT

Treatment or other measures (or a referral when appropriate) are provided to correct or ameliorate physical and/or behavioral health conditions discovered by the screening/diagnostic services.

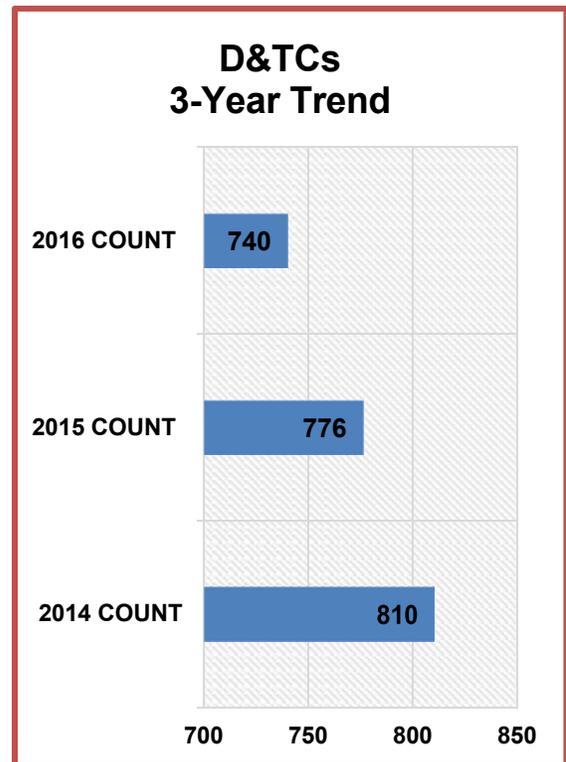
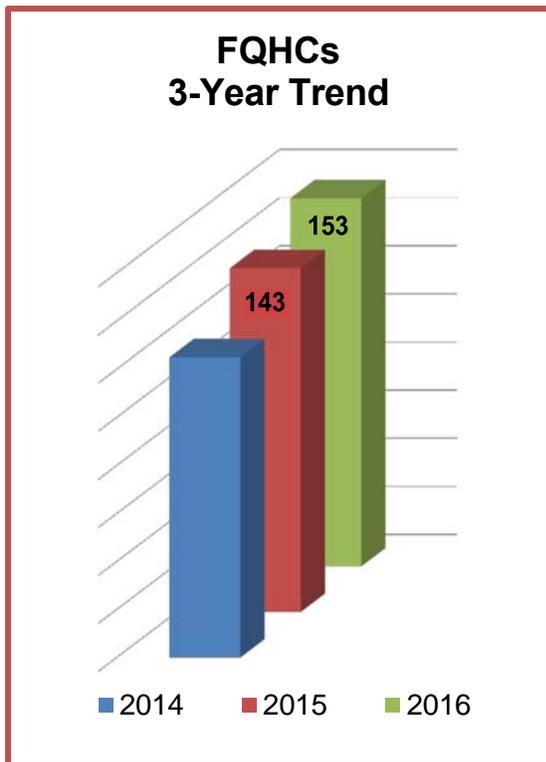
New York State Medicaid Enrolled Primary Care Service Providers

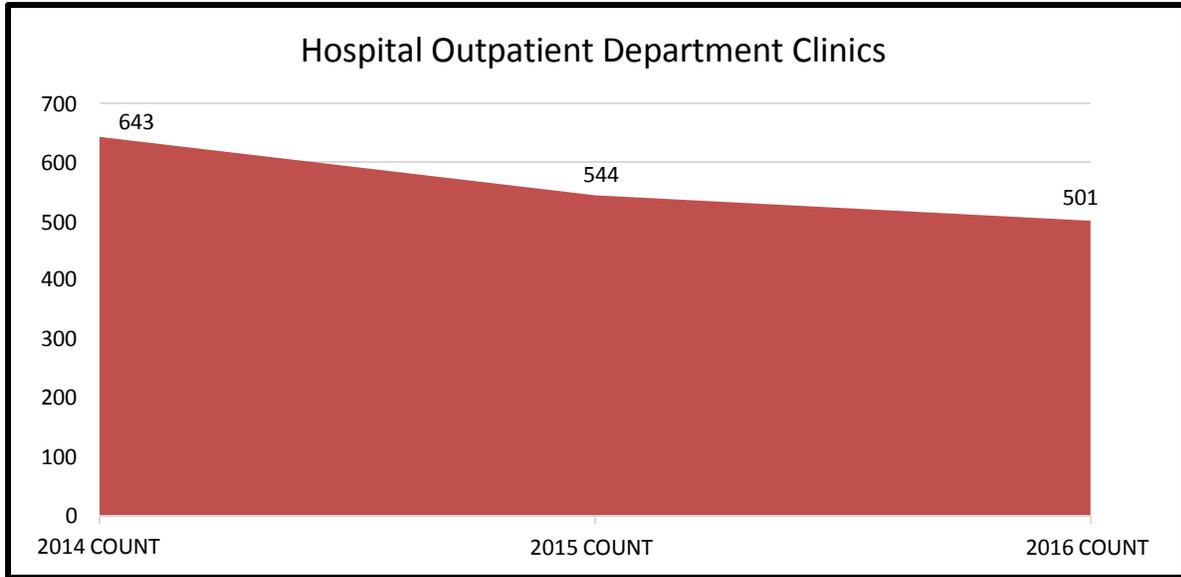
Primary care service provider charts show a three-year trend of enrolled primary care providers.

Primary care services may be provided by an individual practitioner or in a clinic setting.



Federally Qualified Health Centers (FQHCs) and Diagnostic and Treatment Centers (D&TCs)





For a three year trend of enrolled primary care providers using a geographical breakdown by county, refer to Attachment #2 - Primary Care Practitioners and Attachment #3 - Primary Care Clinics.

Physician Specialist Services

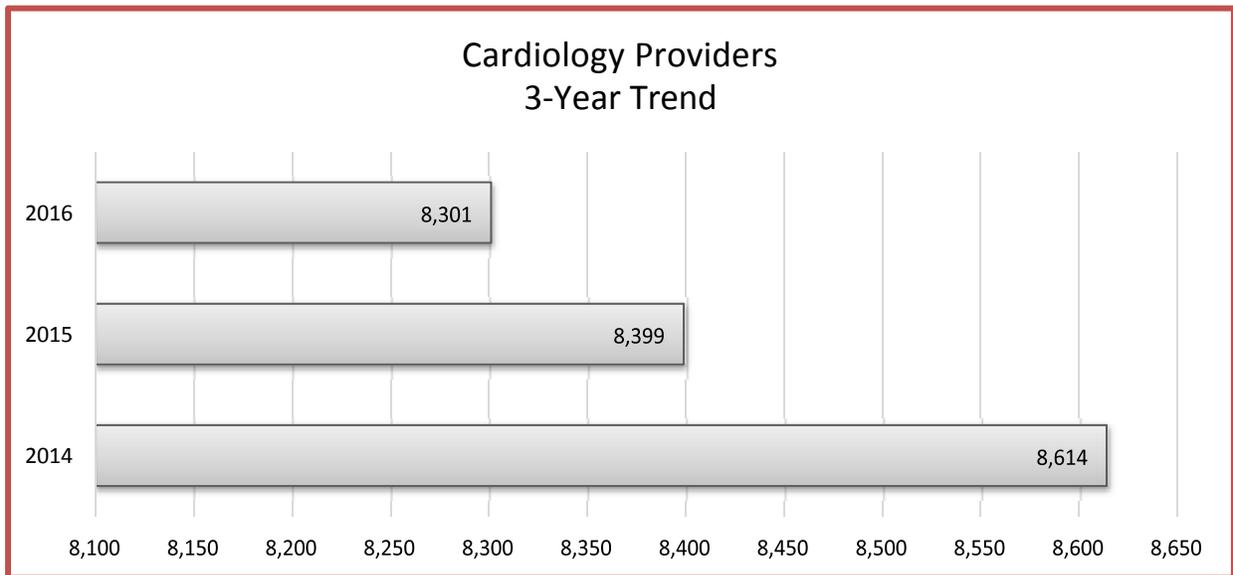
On the basis of standards approved by the State Commissioner of Health, a specialist is a licensed physician who:

- Is a Diplomate of the appropriate American Board, or Osteopathic Board; or
- Has been notified of admissibility to examination by the appropriate American Board, or Osteopathic Board, or presents evidence of completion of an appropriate qualifying residency approved by the American Medical Association (AMA), or American Osteopathic Association; or
- Holds an active staff appointment with specialty privileges in a voluntary or governmental hospital which is approved for training in the specialty in which the physician has privileges; or
- In psychiatry, a physician may be recognized as a specialist if he/she satisfies the following additional alternatives:
 - Has been Chief or Assistant-Chief Psychiatrist in an approved psychiatric clinic and is recommended for approval by the Director of Psychiatry of the Community Mental Health Board; or
 - Graduated from medical school prior to July 1, 1946, and during the last five years has restricted practice essentially to psychiatry, and is certified by the Commissioner of the State Office of Mental Health (OMH) after approval by a committee of the NYS Council of District Branches of the American Psychiatric Association appointed for this purpose by the President of the Council.

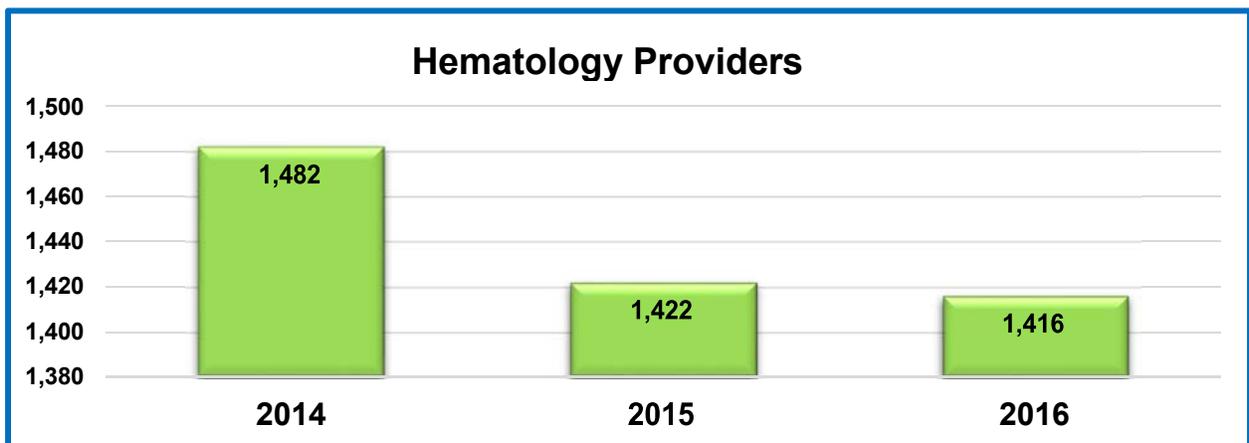
New York State Medicaid Enrolled Physician Specialist Providers

Physician specialist charts show a three-year trend of enrolled physician specialist providers. New York State focused on the following specialties:

- Cardiology,
- Hematology,
- Oncology, and
- Pulmonology.



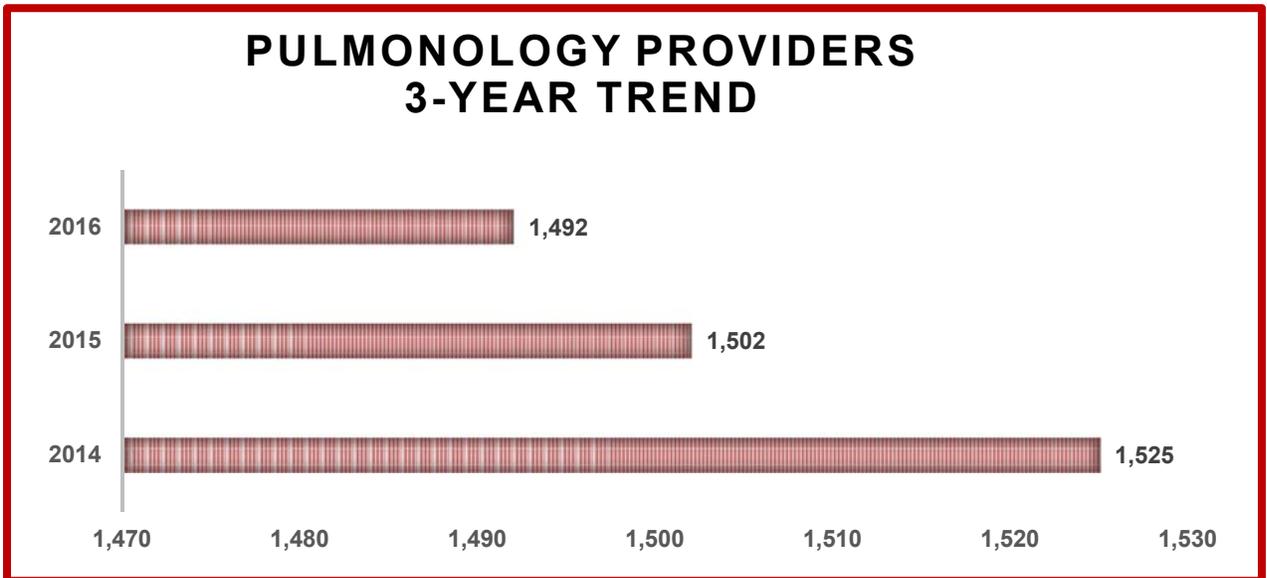
For a three year trend of enrolled Cardiology Providers using a geographical breakdown by county, refer to Attachment #4 – Cardiologists.



For a three year trend of enrolled Hematology Providers using a geographical breakdown by county, refer to Attachment #5 – Hematologists.



For a three year trend of enrolled Oncology Providers using a geographical breakdown by county, refer to Attachment #6 – Oncologists



For a three year trend of enrolled Pulmonology Providers using a geographical breakdown by county, refer to Attachment #7 – Pulmonology.

Behavioral Health Services

Mental Health Services

New York State's mental health service system is overseen by the NYS Office of Mental Health (OMH). OMH plans, develops, and regulates the State's system of mental health treatment, rehabilitation, residential and recovery services provided by counties, voluntary and proprietary ambulatory agencies, general hospitals, private psychiatric hospitals and health clinics and Federally Qualified Health Centers. OMH also operates the State Operated psychiatric centers for adults and children and children's psychiatric centers, providing a broad range of inpatient treatment, outpatient treatment, rehabilitation residential and recovery services. The NYS mental health system overseen by OMH (funded, regulated and/or state-operated) serves more than 750,000 individuals annually.

The following are descriptions of all the services regulated and/or funded by OMH. The listing is extracted from the instructions for completion of the Consolidated Fiscal Report (CFR), which virtually all agencies receiving Medicaid and/or OMH funds are required to submit annually.

Day Treatment (Licensed Program)

Day treatment services for children and adolescents provide intensive, non-residential services. The programs are characterized by a blend of mental health and education services provided in a fully integrated program. Typically, these programs include education in small classes with an emphasis on individualized instruction, individual and group counseling, family services such as family counseling, crisis intervention, interpersonal skill development and behavior modification. Children and adolescents receiving day treatment services live at home or in the community but are identified by their school district as seriously emotionally disturbed and cannot be maintained in regular classrooms.

Assertive Community Treatment (ACT) Program (Licensed Program)

ACT Teams provide mobile intensive treatment and support to people with psychiatric disabilities. The focus is on improving an individual's quality of life in the community and reducing the need for inpatient care, by providing intense community-based treatment services by an interdisciplinary team of mental health professionals. Building on the successful components of the Intensive Case Management (ICM) program, the ACT program has low staff-outpatient ratios; 24-hour-a-day, seven-day-per-week availability; enrollment of consumers, and flexible service dollars. Treatment is focused on individuals who have been unsuccessful in traditional forms of treatment.

Children and Youth Assertive Community Treatment (Licensed Program)

The Child and Adolescent Assertive Community Treatment (ACT) team is a community based program which provides or arranges for services, treatment and support to families with children at significant risk for out-of-home placement for whom traditionally structured services have not met their needs. The team offers a point of responsibility for serving youth with serious emotional disturbance. By providing intensive home and community based services in the youth's home community, the team can preserve family integrity and prevent unnecessary out-of-home placement. Teams employ a wraparound, strength-based care coordination model which is child-centered and family-focused, fundamental to enhancing resiliency, meeting the imperatives of developmental stages and promoting wellness for each child and family. It ensures effective interventions by implementing a creative and collaborative partnership with the family, treatment provider(s), community-based services and other natural supports. Intensive in-home services include case management, therapy, education and skill building services, among others to improve the families and youth's skills and abilities.

Residential Treatment Facility - Children and Youth (Licensed Program)

Residential Treatment Facilities (RTF's) provide fully-integrated mental health treatment services to seriously emotionally disturbed children and youth between the ages of five and 21 years of age. These services are provided in 14-61 bed facilities which are certified by both the Office of Mental Health (OMH) and the Joint Commission on the Accreditation of Health Care Organizations (JCAHO) or Council on Accreditation (COA) To provide comprehensive mental and primary health care services including but not limited to: case coordination services, verbal therapies, medication therapy, therapeutic recreation services, task and skill building vocational training, creative arts therapy, and on-campus school program.

Continuing Day Treatment (Licensed Program)

A continuing day treatment program provides active clinical treatment and psychiatric rehabilitation designed to assess readiness as well as maintain and/or enhance current levels of functioning and skills to maintain community living. Group and individual services develop self-awareness and self-esteem through the exploration and development of patient strengths and interests.

The ultimate goal is for the individual receiving services to achieve desired life roles or goals such as, but not limited to, those related to securing or retaining employment, returning to school, being a parent or spouse, making friends, or accessing generic community resources to meet individual needs. Services should assist individuals in using their inherent strengths and supports to overcome barriers to goal achievement that are caused by their mental health condition.

A continuing day treatment program shall provide the following services: assessment and treatment planning, discharge planning, medication therapy, medication

education, case management, health screening and referral, psychiatric rehabilitation readiness development, psychiatric rehabilitation readiness determination and referral and symptom management. The following additional services may also be provided: supportive skills training, activity therapy, verbal therapy, crisis intervention services and clinical support services.

OMH Licensed Comprehensive Psychiatric Emergency Program (CPEP)

CPEP Crisis Outreach, CPEP Extended Observation Beds, CPEP Crisis Beds, and CPEP Crisis Intervention, provided together, comprise the OMH Licensed Comprehensive Psychiatric Emergency Program (CPEP). One of the four components of this program, CPEP Crisis Beds, is funded outside the Medicaid program.

1. CPEP Crisis Outreach (Non-Licensed Program - Associated with a Licensed CPEP Program) – Comprehensive Psychiatric Emergency Program (CPEP) is a mobile crisis intervention component offering crisis outreach and interim crisis service visits to individuals outside an emergency room setting, in the community in natural (e.g. homes), structured (e.g., residential programs), or controlled (e.g., instructional) environments. Crisis outreach service visits are emergency mental health services provided outside an emergency room which include clinical assessment and crisis intervention treatment. Interim crisis service visits are mental health services provided to individuals who are released from a CPEP for the purpose of facilitating the individual’s community tenure while waiting for the first post-CPEP visit with a community-based mental health provider. CPEP crisis outreach and interim crisis service visits are Medicaid reimbursable.
2. CPEP Extended Observation Beds (Non-Licensed Program – Associated with a Licensed CPEP Program) – Beds operated by the Comprehensive Psychiatric Emergency Program which are usually located in or adjacent to the CPEP emergency room, are available 24 hours per day, seven days per week to provide extended assessment and evaluation as well as a safe and comfortable environment for up to 72 hours for persons, who in the opinion of the examining physicians, require extensive evaluation, assessment, or stabilization of their acute psychiatric symptoms. Extended observation bed services are reimbursed at the inpatient psychiatric rate of the hospital where the CPEP is located.
3. CPEP Crisis Beds (Non-Licensed Program) – CPEP Crisis Beds is a residential (24 hour/day) stabilization component of the CPEP, which provides supportive services for acute symptom reduction and the restoration of patients to pre-crisis level of functioning. These programs are time limited (up to five days) for patients until they achieve stabilization. Crisis beds serve persons experiencing rapid or sudden deterioration of social and personal conditions such that they are clinically at risk of hospitalization but may be treated in this alternative setting. CPEP crisis bed services are neither funded by OMH nor Medicaid-reimbursable, but are purchased from the facility operating these beds.

4. CPEP Crisis Intervention (Licensed Program) – This licensed, hospital-based psychiatric emergency program establishes a primary entry point to the mental health system for individuals who may be mentally ill to receive emergency observation, evaluation, care and treatment in a safe and comfortable environment. Emergency visit services include provision of triage and screening, assessment, treatment, stabilization and referral or diversion to an appropriate program. Brief emergency visits require a psychiatric diagnostic examination and may result in further CPEP evaluation or treatment activities, or discharge from the CPEP program. Full emergency visits must include a psychiatric diagnostic examination, psychosocial assessment and medication examination. Brief and full emergency visit services are Medicaid reimbursable.

Intensive Case Management (Non-Licensed Program)

ICM is set at a case manager/client ratio of 1:12.

Medicaid billing requirements for the Traditional ICM model requires a minimum of four (4) 15 minute face-to-face contacts per individual per month. For programs serving Children and Families, one contact may be collateral. The Flexible ICM model requires a minimum of two (2) 15 minute minimum face-to-face contacts per individual, per month but must maintain a minimum aggregate of 4 face-to-face contacts over the entire caseload. For programs serving Children and Families, 25% of the aggregate contacts can be collaterals.

Supportive Case Management (SCM) (Non-Licensed Program)

SCM is set at a case manager client ratio of 1:20 or 1:30 and Adult Home SCM is set at a case manager client ratio of 1:30. Medicaid billing requires a minimum of two 15 minute face-to-face contacts per individual per month. Collateral contacts are not counted.

Blended Case Management (Non-Licensed Program)

Blended Case Management (BCM) facilitates a team approach to case management by combining the caseloads of multiple Intensive Case Managers (ICMs) and/or Supportive Case Managers (SCMs). Team caseload size and minimum number of aggregate monthly contacts required for Medicaid billing is determined by the mix of ICMs and SCMs on the team. For ICM programs serving Children and Families, 25% of aggregate contacts provided by ICM clients may be collateral. SCM collaterals are not billable.

Clinic Treatment (Licensed Program)

A clinic treatment program shall provide treatment designed to minimize the symptoms and adverse effects of illness, maximize wellness, and promote recovery.

A clinic treatment program for adults shall provide the following services: outreach, initial assessment (including health screening), psychiatric assessment, crisis intervention, injectable psychotropic medication administration (for clinics serving adults), psychotropic medication treatment, psychotherapy services, family/collateral psychotherapy, group psychotherapy, and complex care management. The following optional services may also be provided: developmental testing, psychological testing, health physicals, health monitoring, and psychiatric consultation.

A clinic treatment program for children shall provide the following services: outreach, initial assessment (including health screening), psychiatric assessment, crisis intervention, psychotropic medication treatment, psychotherapy services, family/collateral psychotherapy, group psychotherapy, and complex care management. The following optional services may also be provided: developmental testing, psychological testing, health physicals, health monitoring, psychiatric consultation, and injectable psychotropic medication administration.

Partial Hospitalization (Licensed Program)

A partial hospitalization program (shall provide active treatment designed to stabilize and ameliorate acute symptoms, to serve as an alternative to inpatient hospitalization, or to reduce the length of a hospital stay within a medically supervised program. A partial hospitalization program shall provide the following services: assessment and treatment planning, health screening and referral, symptom management, medication therapy, medication education, verbal therapy, case management, psychiatric rehabilitation readiness determination and referral, crisis intervention services, activity therapy, discharge planning and clinical support services. There are partial hospitalization programs for both children and adults.

Home and Community Based Services (HCBS) Children's Waiver (Non-Licensed Program)

The purpose of the HCBS Children's Waiver, authorized in 1915(c) of the Social Security Act, is to maintain children with serious emotional disturbance (SED) in their homes and communities who would otherwise be in hospital levels of care by reimbursing for non-traditional services. In addition to Individualized Care Coordination, non-traditional services include: Crisis Response, Intensive In-Home, Respite Care, Family Support Services, and Skill Building. This program waives parental deeming (where parental income and resource are disregarded in the Medicaid application for the child). The program operates in all NYS counties except for Oneida, where a look-alike program is in place. Services are provided to eligible children between the ages of 5 and 18 years and their families.

Intensive Psychiatric Rehabilitation Treatment (IPRT) (Licensed Program)

An intensive psychiatric rehabilitation treatment program is time-limited, with active psychiatric rehabilitation designed to assist a patient in forming and achieving mutually agreed upon goals in living, learning, working and social environments; to intervene with psychiatric rehabilitation technologies, to overcome functional disabilities and to improve environmental supports. An intensive psychiatric rehabilitation treatment program shall provide the following services: psychiatric rehabilitation readiness determination, psychiatric rehabilitation goal setting, psychiatric rehabilitation functional and resource assessment, psychiatric rehabilitation service planning, psychiatric rehabilitation skills and resource development and discharge planning.

Teaching Family Home (Licensed Program)

Teaching Family Homes are designed to provide individualized care to children and youth with serious emotional disturbances in a family-like, community-based environment. Specially trained parents live and work with four children and youth with serious emotional disturbances in a home-like setting. The teaching parents are responsible for the social education of the children and the implementation of a service plan developed in conjunction with the family and clinical service provider. The focus is on teaching the youth to live successfully in a family, attend school, and live productively in the community.

This is a type of Licensed Housing/Community Residential program for children and adolescents as defined in 14 NYCRR 594.

Adult Behavioral Health Home and Community Based Services (BH HCBS) Intensive Supported Employment (ISE) (Non-Licensed Program)

ISE services assist individuals with mental health (MH) or substance use disorders (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 is based on 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. The outcome of this activity is documentation of the participant's stated career objective and a career plan used to guide individual employment support.

This program is effective 01/01/2016 for services provided in New York City (NYC), and effective 10/01/2016 for services provided in the rest of the state.

Adult Behavioral Health Home and Community Based Services (BH HCBS) Transitional Employment (Non-Licensed Program)

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.

This program is effective 01/01/2016 for services provided in NYC, and effective 10/01/2016 for services provided in the rest of the state.

Adult Behavioral Health Home and Community Based Services (BH HCBS) Pre-Vocational Services (Non-Licensed Program)

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.

This program is effective 01/01/2016 for services provided in NYC, and effective 10/01/2016 for services provided in the rest of the state.

Adult Behavioral Health Home and Community Based Services (BH HCBS) Empowerment Services - Peer Supports (Non-Licensed Program)

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 a substance use disorder (SUD) and mental health issues. Activities included must be intended to achieve the identified goals or objectives as set forth in the participant's 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.

This program is effective 01/01/2016 for services provided in NYC, and effective 10/01/2016 for services provided in the rest of the state.

Adult Behavioral Health Home and Community Based Services (BH HCBS) Education Support Services (ESS) (Non-Licensed Program)

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 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

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.

This program is effective 01/01/2016 for services provided in NYC, and effective 10/01/2016 for services provided in the rest of the state.

Adult Behavioral Health Home and Community Based Services (BH HCBS) 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.

Please note: BH HCBS services are only available to individuals enrolled in a HARP or HIV SNP, who have been approved for HCBS services in their plan of care. Individuals must have an acute medical condition requiring higher level of care. 7 days maximum per episode.

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.

This program is effective 01/01/2016 for services provided in NYC, and effective 10/01/2016 for services provided in the rest of the state.

Adult Behavioral Health Home and Community Based Services (BH HCBS) Short-Term Crisis Respite (Non-Licensed Program)

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.

This program is effective 01/01/2016 for services provided in NYC, and effective 10/01/2016 for services provided in the rest of the state.

Adult Behavioral Health Home and Community Based Services (BH HCBS) Family Support and Training (FST) (Non-Licensed Program)

Family Support and Training is 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. FST uses 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.

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.

This program is effective 01/01/2016 for services provided in NYC, and effective 10/01/2016 for services provided in the rest of the state.

Adult Behavioral Health Home and Community Based Services (BH HCBS) Habilitation (Non-Licensed Program)

Habilitation services are provided on a 1:1 basis and are designed to assist participants with a behavioral health diagnosis (i.e. substance use disorder (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 a 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 ensure recovery, health, welfare, safety and maximum independence of the participant.

This program is effective 01/01/2016 for services provided in NYC, and effective 10/01/2016 for services provided in the rest of the state.

**Adult Behavioral Health Home and Community Based Services (BH HCBS)
Psychosocial Rehabilitation (PSR) (Non-Licensed Program)**

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., substance use disorder (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.

This service may include 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 that are critical to remaining in home, school, work and community.

This program is effective 01/01/2016 for services provided in NYC, and effective 10/01/2016 for services provided in the rest of the state.

**Adult Behavioral Health Home and Community Based Services (BH HCBS)
Community Psychiatric Support and Treatment (CPST) (Non-Licensed Program)**

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.

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. 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.

This program is effective 01/01/2016 for services provided in NYC, and effective 10/01/2016 for services provided in the rest of the state.

Treatment Congregate (Licensed Program)

Treatment Congregate is a group-living designed residential program which focuses on interventions necessary to address the specific functional and behavioral deficits which prevent residents from accessing generic housing. These interventions are goal-oriented, intensive, and usually of limited duration. Staff is on-site 24 hours/day.

This is a type of Licensed Housing/Community Residential program for adults as defined in 14 NYCRR 595. Medicaid only reimburses for rehabilitation services.

Treatment Apartment (Licensed Program)

Treatment Apartment is an apartment-based residential program which focuses on interventions necessary to address the specific functional and behavioral deficits which prevent residents from accessing generic housing. These interventions are goal-oriented, intensive, and usually of limited duration. Resident/staff contacts occur on a flexible schedule, as appropriate to the needs and desires of the resident.

This is a type of Licensed Housing/Community Residential program for adults as defined in 14 NYCRR 595.

Comprehensive PROS with Clinic (Licensed Program)

Personalized Recovery Oriented Services (PROS) is a comprehensive recovery oriented program for individuals with severe and persistent mental illness. The goal of the program is to integrate treatment, support and rehabilitation in a manner that facilitates the individual's recovery. Goals for individuals in the program are to: improve functioning, reduce inpatient utilization, reduce emergency services, reduce contact with the criminal justice system, increase employment, attain higher levels of education and secure preferred housing. There are four "service components" in the program: Community Rehabilitation and Support (CRS), Intensive Rehabilitation (IR), Ongoing Rehabilitation and Support (ORS) and Clinical Treatment. Age of eligibility begins at 18.

Comprehensive PROS without Clinic (Licensed Program)

Personalized Recovery Oriented Services (PROS) is a comprehensive recovery oriented program for individuals with severe and persistent mental illness. The goal of the program is to integrate treatment, support and rehabilitation in a manner that facilitates the individual's recovery. Goals for individuals in the program are to: improve functioning, reduce inpatient utilization, reduce emergency services, reduce contact with the criminal justice system, increase employment, attain higher levels of education and

secure preferred housing. There are four "service components" in the program: Community Rehabilitation and Support (CRS), Intensive Rehabilitation (IR), Ongoing Rehabilitation and Support (ORS) and Clinical Treatment. This program does not include the optional Clinic Treatment component.

Limited License PROS (Licensed Program)

Personalized Recovery Oriented Services (PROS) is a comprehensive recovery oriented program for individuals with severe and persistent mental illness. The goal of the program is to integrate treatment, support and rehabilitation in a manner that facilitates the individual's recovery. Goals for individuals in the program are to: improve functioning, reduce inpatient utilization, reduce emergency services, reduce contact with the criminal justice system, increase employment, attain higher levels of education and secure preferred housing. A Limited License PROS program provides only Ongoing Rehabilitation and Support (ORS) and Intensive Rehabilitative Services (IR).

Supportive Case Management (SCM) (Non-Licensed Program)

SCM is set at a case manager client ratio of 1:20 or 1:30 and Adult Home SCM is set at a case manager client ratio of 1:30. Medicaid billing requires a minimum of two 15 minute face-to-face contacts per individual per month. Collateral contacts are not counted.

Adult Home Supportive Case Management (Non-Licensed Program)

SCM is provided to adult home residents by Supportive Case Managers who work as a team with Peer Specialists as part of an integrated approach to addressing the needs of the adult home population. Each Case Manager and Peer Specialist team serves a maximum of 30 residents. A Supervising Case Manager or Coordinator of Case Management provides supervision to the SCM and Peer Specialists. Adult Home Case Management takes referrals from the adult home and does not take referrals from a single point of access (SPOA).

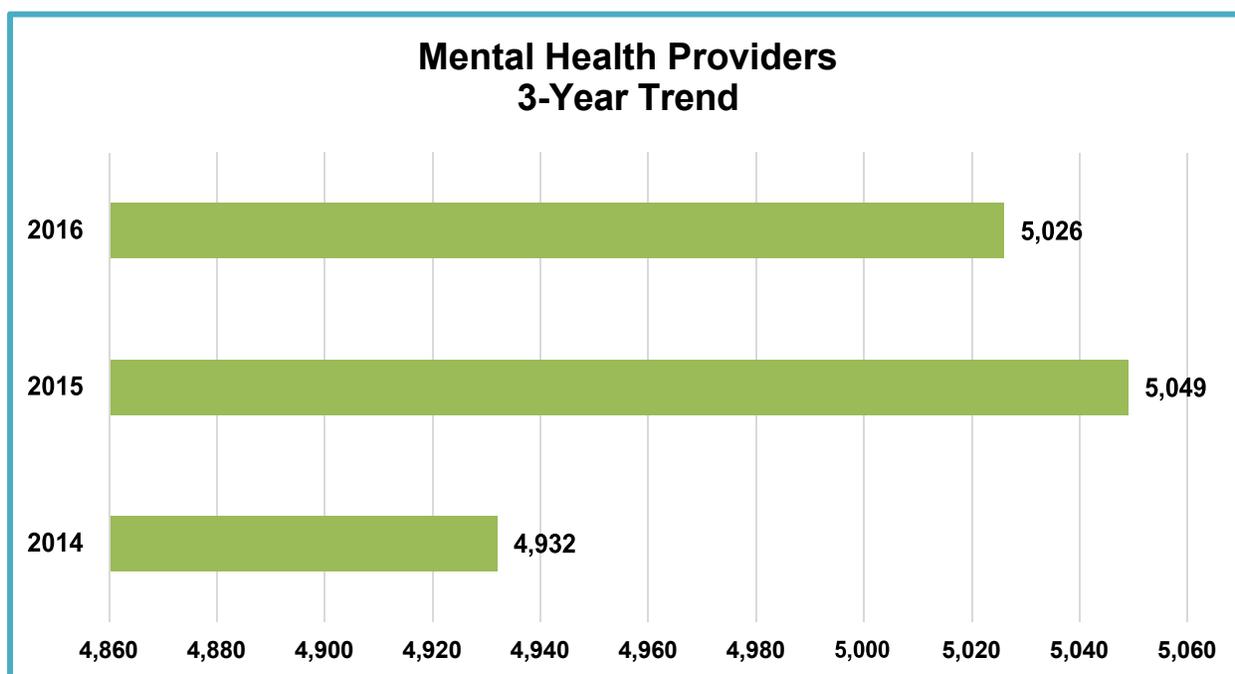
When an Adult Home resident moves to other community housing, and no longer needs SCM, the recipient will then be eligible for transitional status, receiving one visit per month for billing (this status may be active for a maximum of two months). When an Adult Home resident moves to other community housing and continues to need the SCM level of care (or the higher ICM level), it is expected that a request for community case management enrollment is processed through the local SPOA. Where a community case management waiting list exists, the Adult Home Case Management program can continue to support that person in the other community setting until the person is transferred to community case management. If the recipient is enrolled in community case management at the time of the move out of the Adult Home, the recipient is not eligible for transitional status.

Medicaid billing requires a minimum of two 15 minute face-to-face contacts per month. Collateral contacts are not billable.

New York State Medicaid Enrolled Mental Health Providers

New York State's mental health service system is overseen by the NYS Office of Mental Health (OMH). OMH plans, develops, and regulates the State's system of mental health treatment, rehabilitation, residential and recovery services provided by counties, voluntary and proprietary ambulatory agencies, general hospitals, private psychiatric hospitals and health clinics and Federally Qualified Health Centers. OMH also operates the State Operated psychiatric centers for adults and children and children's psychiatric centers, providing a broad range of inpatient treatment, outpatient treatment, rehabilitation residential and recovery services.

The chart, *Mental Health Providers*, shows a three-year trend of enrolled mental health providers.



For a three year trend of enrolled Mental Health Providers using a geographical breakdown by county, refer to Attachment #8 – Mental Health Services.

Behavioral Health Services

Alcohol and Substance Abuse Services

New York State's substance use disorder treatment system is overseen by the NYS Office of Alcoholism and Substance Abuse Services (OASAS). OASAS plans, develops, and regulates the State's system of substance use disorder and gambling treatment agencies; directs operation of 12 Addiction Treatment Centers, providing inpatient rehabilitation services to approximately 10,000 persons per year; and licenses, funds, and supervises nearly 1,000 community-based substance use disorder treatment programs, which serve approximately 100,000 persons on any given day.

The following services are Medicaid state plan services billed by providers certified by OASAS and/or dually licensed by the NYS Department of Health. These services can be billed fee-for-service for individuals who are not enrolled in a managed care plan and all (except Residential Rehabilitation Services for Youth - RRSY) are in the managed care benefit package for managed care enrollees. The RRSY service will be a managed care benefit service beginning in 2017 when the state begins to carve-in behavioral health benefits for youth.

Outpatient Services

- **Outpatient Medically Supervised Withdrawal:**
 - Clients have moderate substance withdrawal and do not meet admission criteria for medically managed detoxification. Clients may also have emotional support from a home environment. Clients are seen by a medical professional daily, receive counseling, and may access a 24-hour hotline. Services may be provided in programs that are dually certified as an Article 28 (DOH) and Article 32 (OASAS) service in a hospital or in freestanding community based programs.

- **Medically Supervised Outpatient**
 - Programs that assist individuals who suffer from addiction, substance use disorders, chemical abuse or dependence and their family members and/or significant others through group and individual counseling; education about, orientation to, and opportunity for participation in, relevant and available self-help groups; alcohol and substance abuse disease awareness and relapse prevention; HIV and other communicable diseases, education, risk assessment, supportive counseling and referral; and family treatment. In addition, social and health care services, skill development in accessing community services, activity therapies, information and education about nutritional requirements, and vocational and educational evaluation must be available either directly or through

written agreements. Procedures are provided according to an individualized assessment and treatment plan. This service mandates that medical staff be part of the multi-disciplinary team and the designation of a Medical Director, which provides for medical oversight and involvement in the provision of outpatient services. Services may be provided in programs that are dually certified as an Article 28 (DOH) and Article 32 (OASAS) service in a hospital or in freestanding community based programs.

- **Outpatient Rehabilitation Services**

- Programs serve more chronic individuals who have inadequate support systems, and either have substantial deficits in functional skills or have health care needs requiring attention or monitoring by health care staff. These programs provide social and health care services, skill development in accessing community services, activity therapies, information and education about nutritional requirements, and vocational and educational evaluation. Clients initially receive these procedures five days a week for at least four hours per day. There is a richer staff to client ratio for these services compared to other outpatient levels and these services are required to have a half-time staff person qualified in providing recreation and/or occupational services as assistant or registered nurse. Like half-time nurse practitioner, physician medically supervised outpatient, outpatient rehabilitation services, mandate that medical staff be part of the multi-disciplinary team and the designation of a Medical Director, which provides for medical oversight and involvement in the provision of outpatient services. Services may be provided in programs that are dually certified as an Article 28 (DOH) and Article 32 (OASAS) service in a hospital or in freestanding community based programs.

- **Opioid Treatment Programs (OTPs)**

Medication assisted treatment delivered by programs primarily on an ambulatory basis, in conjunction with a variety of other rehabilitative services to control the physical problems associated with opioid dependence and to provide the opportunity for patients to make major life style changes over time. Rehabilitative services may include primary medical care, counseling and other support services. Medication is administered daily at a stabilized dose over an extended period of time. Methadone may be prescribed and administered through a variety of medical protocols, as per individual needs: including Maintenance, Methadone to Abstinence, Medically supervised Withdrawal, Levo-Alpha-Acetylmethadol (LAAM), and Key Extended Entry Program (KEEP). Services may be provided in programs that are dually certified as an Article 28 (DOH) and Article 32 (OASAS) service in a hospital or in freestanding community based programs.

Inpatient/Residential Services

- **Medically Managed Detoxification:**
 - Patients in these programs are acutely ill and may be experiencing severe withdrawal symptoms and/or a risk of psychiatric co-morbid conditions. Admissions to these programs may be involuntary, emergency admissions. Programs are dually certified as an Article 28 (DOH) and Article 32 (OASAS) service in a hospital. There is a 5-day average length of stay in these programs. Patients stabilized at this level “step down” to a medically supervised service.
- **Medically Supervised Withdrawal and Stabilization:**
 - Patients in these programs have mild to moderate withdrawal, situational crises, and are unable to abstain without withdrawal symptoms. Services include medical supervision and direction and may be provided in programs that are dually certified as an Article 28 (DOH) and Article 32 (OASAS) service in a hospital or in freestanding community based programs. Patients stabilized at this level typically “step down” to a medically supervised outpatient service.
- **Inpatient Rehabilitation**
 - Providers in these programs conduct intensive evaluation, treatment and rehabilitation services in a medically supervised 24 hour/day, 7 days/week setting that provides intensive management of SUD symptoms and medical management/monitoring of physical or mental complications from SUD to clients who cannot be effectively served as outpatients and who are not in need of medical detoxification or acute care. Services are provided according to an individualized treatment plan and under the supervision of a Medical Director. These services can be provided in a hospital or freestanding community based facility. The state also operates 12 addiction treatment centers that offer this level of care. Average length of stay is 21 to 28 days.
- **Community Based Residential Addiction Services**
 - Community Based Residential Addiction Services include individual-centered residential services consistent with the individual’s assessed treatment needs, with a rehabilitation and recovery focus designed to promote skills for coping with and managing substance use disorder symptoms and behaviors. These services are designed to help individuals achieve changes in their substance use disorder behaviors. Services address an individual’s major lifestyle, attitudinal, and behavioral problems that have the potential to undermine the goals of treatment. Residential

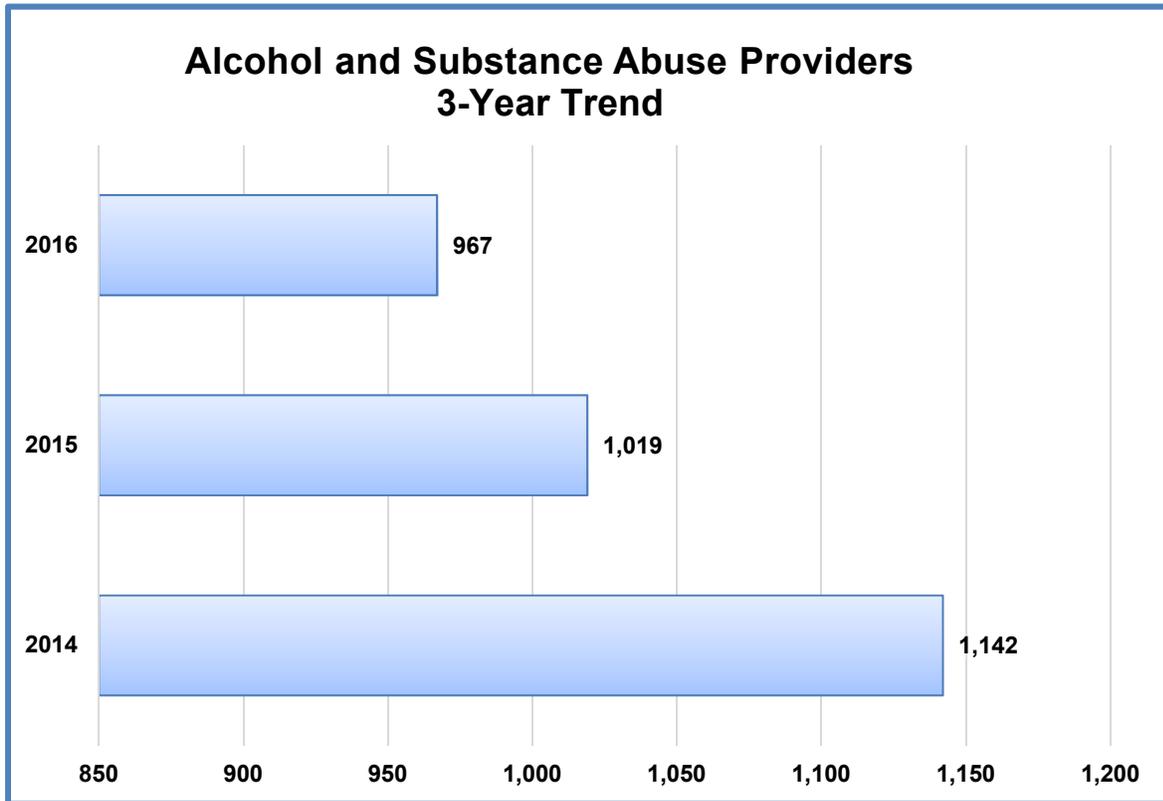
services are delivered on an individual or group basis in a wide variety of settings community based settings.

- **Residential Rehabilitation Services for Youth**

- o Residential Rehabilitation Services for Youth (RRSY) is an inpatient treatment program which provides active treatment to adolescents in need of substance use disorder. Services provided include individual and group counseling, family counseling, as appropriate, recovery support services, education about communicable diseases, introduction to peer-support and self-help groups, life skills training, holistic health education, case management/community support services, vocational and educational assessment and referral, and medical and psychiatric consultation. Active treatment is provided through a multi-disciplinary team. In an RRSY program, the multi-disciplinary team defined in Part 800 of OASAS' regulations is expanded to include (1) a psychiatrist, or a physician and a clinical psychologist and (2) a clinical social worker (CSW) or a Registered Professional Nurse (RN) or an Occupational Therapist. Admission to an RRSY is based on a Pre-Admission Certification by an Independent Pre-Admission Certification team. Services are delivered by freestanding community based providers.

New York State Medicaid Enrolled Alcohol and Substance Abuse Providers

Alcohol and Substance Abuse providers are certified by OASAS and/or dually licensed by the NYS Department of Health. The chart, *Alcohol and Substance Abuse Providers*, shows a three-year trend of enrolled alcohol and substance abuse providers.



For a three year trend of enrolled Alcohol and Substance Abuse Providers using a geographical breakdown by county, refer to Attachment #9 – Alcohol and Substance Abuse.

Prenatal and Postnatal Care Services

Prenatal care services, including prenatal diagnostic and treatment services, provided to pregnant women and postpartum women shall meet generally accepted standards of care as described by the most current American Academy of Pediatrics (AAP) and American College of Obstetricians and Gynecologists (ACOG) guidelines for perinatal care and shall be provided by a qualified provider practicing as:

- A licensed physician practicing in accordance with Article 131 of the New York State Education Law who is either an obstetrical care physician (MD/DO), Board Certified or Board Eligible in their area of specialty, or who has completed an accredited residency program in Family Practice or Obstetrics/Gynecology;
- A nurse practitioner practicing in accordance with Article 139 of the New York State Education Law;
- A licensed midwife practicing in accordance with Article 140 of the New York State Education Law; or
- A registered physician's assistant practicing in accordance with Part 94 of this Title, Article 37 of the NYS Public Health Law and Article 131 of the NYS Education Law.

Prenatal Care

Prenatal care providers shall provide pregnant women timely access and referral to appropriate levels of prenatal care, (basic, specialty, and subspecialty), based on assessed risk status in order to prevent, recognize and treat conditions associated with maternal and infant mortality and morbidity.

- Any pregnant woman who presents for prenatal care should begin receiving care as quickly as possible, preferably the same day. All prenatal care service providers must provide prenatal care services to recipients determined to be presumptively eligible for medical assistance but are not yet enrolled in Medicaid.
- Prenatal care providers shall assist or refer women for assistance with application for medical assistance and managed care plan selection in accordance with procedures established by the Commissioner of Health.
- Prenatal care practices must provide or arrange for the provision of 24 hour/7 day/ week coverage (an after-hours and weekend/vacation number to call that leads to a person or message that will result in the call being returned by a health care professional within one hour). Pregnant women shall have access to unscheduled or emergency visits on a 24 hour basis.
- Prenatal care providers must develop or arrange for systems for reminder/call backs to patients needing continued or follow-up services, and for visits requiring follow-up for abnormal test results. Prenatal care providers shall outreach to patients to reschedule missed appointments in a manner that maintains patient confidentiality.

- Prenatal care providers shall schedule prenatal care visits for an uncomplicated pregnancy consistent with AAP/ACOG recommendations. Pregnant women with medical, obstetrical and/or psychosocial problems may require more frequent visits. The need for increased surveillance is best determined by the prenatal care provider based on the individual needs of the woman, and the nature and severity of her problems.

Postnatal Care

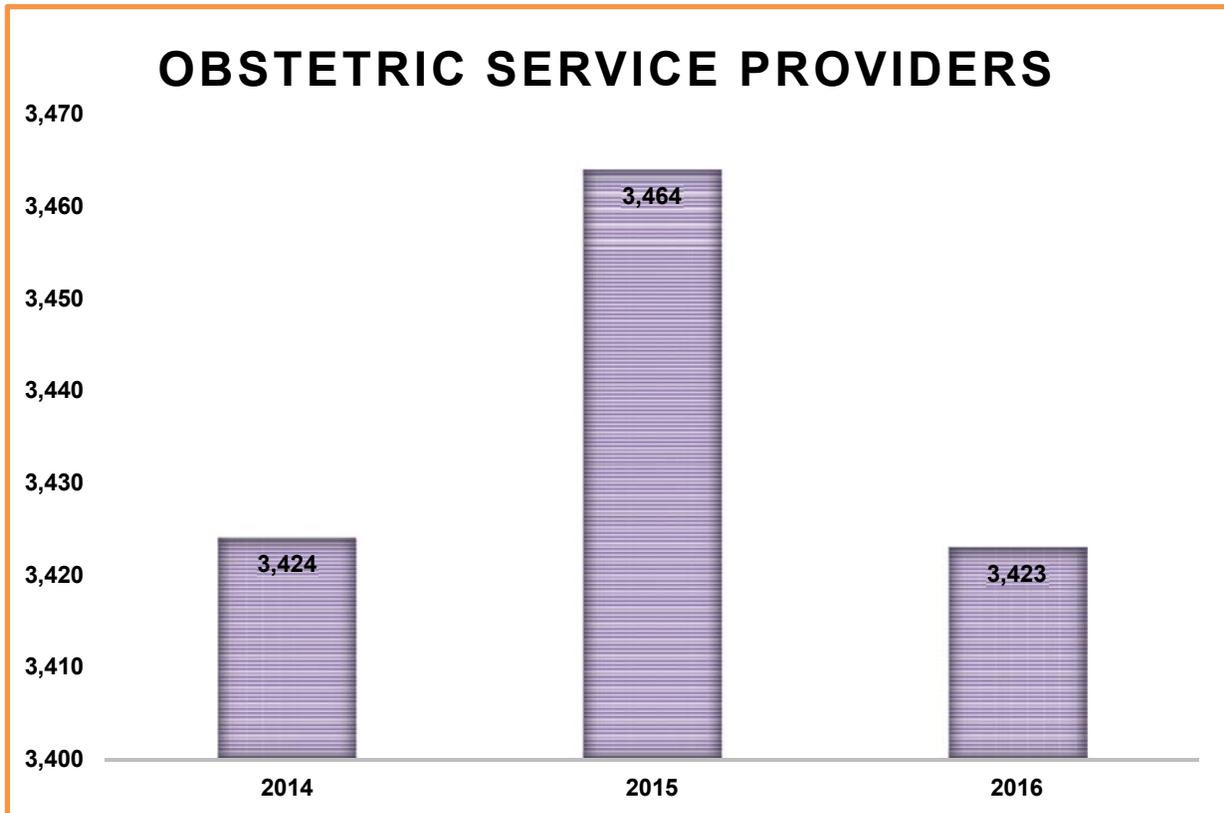
The prenatal care provider shall schedule a postpartum visit based on the woman's identified needs and in accordance with AAP/ACOG's recommended schedule, (approximately 4 - 6 weeks after delivery but no later than eight weeks after delivery; women with a complicated gestation or delivery by cesarean section should have a visit scheduled within 7 - 14 days of delivery). The visit should include an interval history and a physical examination to evaluate the patient's current status and her adaptation to the newborn.

For more information on New York State's Pre/Postnatal Care Standards go to:

http://www.health.ny.gov/health_care/medicaid/standards/prenatal_care/

New York State Medicaid Enrolled Prenatal and Postnatal Providers

Prenatal and postnatal service providers (obstetric service providers) include physicians, nurse practitioners, and midwives. The chart, *Obstetric Service Providers*, shows a three-year trend of enrolled obstetric service providers having a specialty in the provision of obstetric/gynecological services.



For a three year trend of enrolled prenatal/postnatal service (obstetric) service providers using a geographical breakdown by county, refer to Attachment #10 – Prenatal and Postnatal Providers.

Home Health Services

Certified Home Health Agencies

Certified Home Health Agencies (CHHAs) provide part-time, intermittent health care and support services to individuals who need intermediate and skilled health care in the home. CHHAs can also provide long-term nursing and home health aide services, can help patients determine the level of services they need, and can either provide or arrange for other services including physical, occupational, and speech therapy, medical supplies and equipment, and social worker and nutrition services. Services provided by CHHAs may be reimbursed by Medicare, Medicaid, private payment, and some health insurers. The NYS Department of Health is responsible for monitoring the care provided by certified home health agencies.

Quality measurement data are available for this provider type. In addition, the Department of Health conducts periodic surveys and investigates complaints at these agencies. If there are findings that a violation of rules and regulations exist during such activities, a written report called a Statement of Deficiencies is issued and the agency must submit a plan of correction to the Department within 10 days. This plan must specifically indicate how the agency will return to and maintain compliance with each rule or regulation it violated. **The most recent inspection data is published on this site.**

Special Needs CHHAs

A Special Needs CHHA is a Certified Home Health Agency that has been approved by the Department of Health to serve an identified specific targeted population or identified special needs population.

- **Populations eligible for services from the Office of Mental Health (OMH) or Office for People with Developmental Disabilities (OPWDD):** The Special Needs Certified Home Health Agency provides services to a population of patients in their homes who would otherwise require care in a facility or program licensed by either OMH or OPWDD.
- **Pilot Program Home Health Agencies:** Ten such agencies are permitted under regulations to provide services to a particular population group and that population group's identified special needs. During the application process, these agencies demonstrated that they were better able than other certified home health agencies to meet the special needs of the defined population group in the areas of improved continuity of care, access to services, cost effectiveness and efficiency.

To view special needs agencies:

https://profiles.health.ny.gov/home_care/special_needs

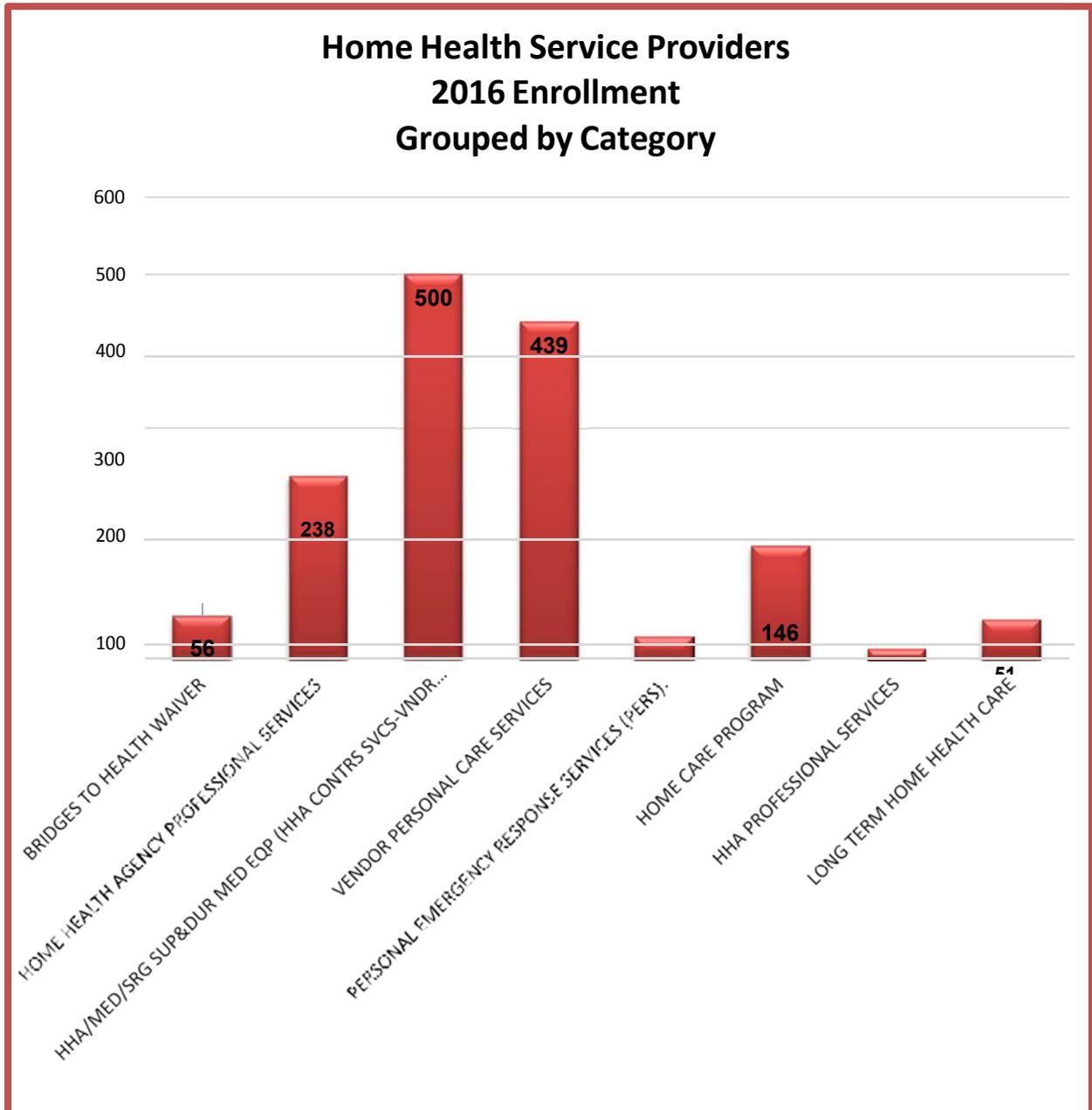
Long Term Home Health Care Programs

Long Term Home Health Care Programs (LTHHCPs) as a provider type are qualified to participate as a home health agency and participate in the Medicare and Medicaid program. Long Term Home Health Care Program providers provide, at a minimum, the following services which are of a preventive, therapeutic, rehabilitative, health guidance and/or supportive nature to persons at home: nursing services, home health aide services, medical supplies, equipment and appliances suitable for use in the home, and at least one additional service which may include but is not limited to physical therapy, occupational therapy, speech pathology, nutritional services and medical social services.

The NYS Department of Health is responsible for monitoring the care provided by home care agencies. Complaints, questions, or concerns about any certified home health agencies should be directed to the Home Health Hotline (800-628-5972). Complaints may also be submitted at https://profiles.health.ny.gov/home_care/pages/complaints.

New York State Medicaid Enrolled Home Health Service Providers

The Home Health benefit covers a variety of skilled care services. Home health service providers include several provider types. The chart, *Home Health Service Providers*, shows the various provider types and highlights the 2016 enrolled providers.



For a three year trend of enrolled Home Health Service Providers using a geographical breakdown by county, refer to Attachment #11 – Home Health Providers.

XI. Summary/Conclusion

In accordance with 42 CFR 447.203, New York State developed its Access Monitoring Review Plan (AMRP) to provide a basis to measure access to care for Medicaid members receiving care under a fee-for-service (FFS) arrangement. New York State has a total population of 19.8 million, with approximately 6.3 million New Yorkers (32.3%) enrolled in the New York State Medicaid program.

New Yorkers may access New York State's marketplace, NY State of Health, using a single application to check their eligibility for health care programs like Medicaid, Child Health Plus, and the new Essential Plan and enroll in these programs if they are eligible. Individuals, families and small businesses can use the Marketplace to help them compare insurance options, calculate costs and select coverage.

New York State maintains a call center to assist members enrolled and wanting to enroll in a health insurance program. The Call Center tracks and monitors all calls. For the month of July 2016, the total number of calls received was 148,668. The Coverage Lookup category received the highest percentage of calls, totaling 43.1% or 64,271, while the Complaint category was only 2% or 2,612.

As the *New York State Medicaid Population As Of 12/20/2015* (page 12) demonstrates, New York State has very few Medicaid enrollees that do not enroll in a managed care plan. Since the implementation of the Affordable Care Act, which requires providers to enroll in Medicaid to be able to write an order/referral for services for a Medicaid member, the number of Medicaid-enrolled providers has greatly increased, (Attachment 2).

New York State developed this Access Monitoring and Review Plan in accordance with 42 CFR 447.203 for the following services (AMRP services) provided under a fee-for-service (FFS) arrangement:

- Primary care services;
- Physician specialist services;
- Behavioral health services;
- Prenatal and postnatal obstetric services, including labor and delivery; and
- Home health services.

Analysis of the data and information contained in this report show that New York State Medicaid fee-for-service members (currently less than one percent of the State's Medicaid population), have appropriate access to healthcare. Factors that lead to this conclusion include: 1) the large number of Medicaid enrolled providers, which ensures access to healthcare; 2) the ability of Medicaid FFS members to obtain services in a wide variety of settings; and 3) the relatively small number of complaints coming into New York's Medicaid Helpline, suggesting that members are currently receiving healthcare that meets their needs. Going forward, the Medicaid program will monitor

provider enrollment increases and decreases and assess impact on patient care and will continue to monitor complaints and address issues as they arise.

The Access Monitoring Review Plan was developed during the 2016 year and posted for comment on the New York State Department of Health website on October XX, 2016.

XII. Attachments

Attachments to New York State's Access Monitoring Review Plan – 2016 include:

- Attachment #1 – Helpline Data
- Attachment #2 – Primary Care Practitioners
- Attachment #3 – Primary Care Clinics
- Attachment #4 – Cardiology
- Attachment #5 – Hematology
- Attachment #6 – Oncology
- Attachment #7 – Pulmonology
- Attachment #8 – Mental Health Providers
- Attachment #9 – Alcohol and Substance Abuse Providers
- Attachment #10 – Prenatal and Postnatal Providers
- Attachment #11 – Home Health Service Providers