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LOCAL COMMISSIONERS MEMORANDUM

Transmittal No: 92 LCM-87

Date: June 16, 1992

Division: Medical Assistance

TO: **Local District Commissioners**

SUBJECT: Managed Special Care Regulations

ATTACHMENTS: Draft Special Care Regulations
(Available On-Line)

The purpose of this letter is to apprise you of the status of our efforts to develop managed special care regulations. As you know, we have recently reached an agreement with each of the relevant State agencies on the content of the regulations. We have begun the clearance process here at SDSS, and hope to publish these regulations as soon as we can. A copy of the most current draft is attached, for your information.

These regulations are the product of very difficult negotiations in which we have tried to balance the interests of Medicaid clients, providers, and the various State and local governmental agencies.

The regulations are required by Chapter 165 of the Laws of 1991. This legislation requires the submission of a managed care plan by each social services district. The special care provisions of Chapter 165 established additional requirements governing the provision of special care services to individuals who require special care on more than an incidental basis. The additional requirements are: 1) a plan must be submitted by a district in order to provide special care services to this population; 2) any such plan must be developed in conjunction with the local mental hygiene director; 3) the plan must provide participants who require special care on more than an incidental basis with a managed special care provider to arrange access to special care services; and 4) the plan must be approved by SDSS and the responsible State special care agency.

To summarize the intent of the regulations, their major purposes are: 1) to define the population which requires special care on more than an incidental basis; 2) to establish the qualifications of managed special care providers; and 3) to establish requirements governing the special care provisions of managed care plans.

Regarding the definition of who requires special care on more than an incidental basis, the regulations distinguish between individuals who are in managed care programs, and those who are not. Anyone who is not in a managed care program, and has had one inpatient stay, certain kinds of specialized ambulatory services, or 10 or more outpatient clinic visits would meet the definition.

The second part of the definition covers any individual, including those in managed care programs, and deems such individuals to require special care on more than an incidental basis if they have a designated mental illness diagnosis and are determined to require services beyond those available from the managed care provider. This will have to be an individual determination, made locally by the local mental hygiene director or a designee of the responsible special care agency. The responsible State special care agencies will be contacting their local respresentatives regarding their role in this process.

There are additional components to the definition which apply only to specific parts of the population. These will be explained in more detail in the forthcoming ADM, and are included in the attached draft regulations.

Each quarter, SDSS will produce an updated listing of those individuals who meet the definition by virtue of their historical utilization of services paid by Medicaid, and transmit it to local social services districts. These individuals may only enroll in managed care programs which have been included in a county managed special care plan which has been approved by SDSS and the responsible special care State agency.

The regulations also establish the requirements for managed special care providers. In order to facilitate managed care providers becoming managed special care providers, the State Department of Health has agreed to establish new actuarial classes for individuals who require special care on more than an incidental basis. This will allow MMIS to pay enhanced rates for this population to HMOs and other full risk programs which have agreed to become managed special care providers.

I have also asked DOH to work with us to establish new rates for this population which exclude mental health services. This will enable districts to contract with HMOs to provide health care services, while the mental health services are provided by licensed mental health providers.

Local districts should be prepared to implement these regulations on October 1, 1992. HMO rates will change effective January 1, 1993, through the establishment of new actuarial classes for the population which requires special care on more than an incidental basis. Local districts are encouraged to work with local mental hygiene officials to develop managed special care programs for this population. Technical assistance is available from SDSS from the Bureau of Primary Care. Contact your managed care county representative for further information at 1-800-342-3715 ext. 3-5957; electronic mail user # OLT080.

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Division of Medical Assistance

DRAFT

Subpart 360-11
Special Care in Managed Care Programs

Sections

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Section 360-11.1 Policy.

(a) The regulations contained in this Subpart implement subdivision 21 of Section 364-j of the Social Services Law, as amended by Chapter 165 of the Laws of 1991. Chapter 165 requires the establishment of managed care programs (MCPs) throughout the State and subdivision 21 provides for the furnishing of special care within MCPs. Special care refers to MA covered treatment of mental illness, mental retardation, developmental disabilities, alcoholism, alcohol abuse and substance abuse.

(b) Special care is not required to be included in an MCP. However, subdivision 21 provides that MCPs which include the furnishing of special care to participants who require special care on more than an incidental basis must make a managed special care provider available to arrange access to special care for these participants. A managed special care provider in an MCP must possess expertise and resources sufficient to assure delivery of timely, quality special care.

(c) MCPs which include the furnishing of special care to participants who require special care on more than an incidental basis must develop managed care plan provisions relating to special care in coordination with managed care providers, local mental hygiene directors and community services boards. Such special care provisions of a managed care plan must be approved by the Department and the State agency with oversight responsibility for the type of special care being offered.

Section 360-11.2 Scope. This subpart establishes:

(a) requirements relating to the inclusion of special care in an MCP;

(b) requirements for a managed care plan which includes special care;

(c) review process for special care provisions of a managed care plan;

(d) criteria for identification of MA recipients requiring special care on more than an incidental basis;

(e) requirements for participant choice of managed special care provider; and

(f) qualifications and standards for managed special care providers.

Section 360-11.3 Definitions. As used in this Subpart unless expressly stated otherwise or unless the context of the subject matter requires a different interpretation:

(a) Terms defined in Section 360-10.3 of Subpart 360-10 shall have the same meaning when used in this Subpart.

(b) Special care means MA care, services and supplies relating to the treatment of mental illness, mental retardation and developmental disabilities, alcoholism, alcohol abuse or substance abuse.

(c) Managed special care provider means an entity that provides, directly or indirectly (including by referral), either special care services, or special care services in conjunction with other MA services, as part of an MCP.

(d) Responsible special care agency (RSCA) means whichever of the following state agencies has responsibility for the special care in question: the Office of Mental Health (OMH), the Office of Mental Retardation and Developmental Disabilities (OMRDD); and the Division of Alcoholism, Alcohol Abuse and Substance Abuse Services (DAAA/DSAS).

Section 360-11.4 Inclusion of special care in managed care program.

(a) A social services district's MCP may include special care for managed care participants. If special care is included in the MCP, the managed care plan must specify whether persons who need special care on more than an incidental basis are to be served by the plan.

(b) If an MCP includes special care for participants who require special care on an incidental basis only, the managed care plan must include:

(1) the process by which access to special care will take place including, but not limited to, access required when:

(i) the participant is identified as requiring special care while participating in primary or other health care offered by the managed care provider; or

(ii) the participant is identified as requiring special care while seeking emergency services; or

(iii) the participant directly requests special care from a provider of special care other than the managed care provider; and

(2) the procedures to be followed when a participant receives special care from the managed care provider, including but not limited to:

(i) the provision of basic information and educational materials about special care;

(ii) the screening of a participant to determine general need for special care;

(iii) the conduct of a comprehensive pre-treatment assessment of a participant to identify the specific need for special care;

(iv) the provision of special care by the managed care provider either directly or by referral to a special care provider, or managed special care provider, if appropriate.

(3) a description of crisis services for participants in need of special care and the process for gaining access.

(c) If an MCP includes special care for participants who require special care on more than an incidental basis, the managed care plan must conform to the requirements of this Section as well as Sections 360-11.5 through 360-11.9.

(d) If an MCP does not include special care for managed care participants, the managed care plan must explain how participants are to access special care.

Section 360-11.5 Requirements for managed care plan in managed care program which includes special care on more than incidental basis.

(a) A managed care plan which includes special care for participants who require special care on more than an incidental basis must specify the process under which MCP participants requiring special care will be identified in accordance with Section 360-11.7, both at time of enrollment and thereafter, and provided with a managed special care provider to obtain access to special care. The responsibilities of the social services district, the managed care provider and the local mental hygiene director, or designee of the RSCA, must be described.

(b) The special care provisions of a managed care plan which includes special care for participants who require special care on more than an incidental basis must be developed in coordination with the managed care providers participating in the MCP, the local mental hygiene director, or designee of the RSCA, and the community services board.

(c) The special care provisions of such a managed care plan must include:

(1) a provider network adequate to meet the needs of participants who require special care;

(2) requirements for coordinated treatment planning to integrate health and special care needs of a participant receiving special care from a provider other than the managed care provider;

(3) the process and time intervals for periodic coordinated review by managed care and managed special care providers of treatment plans and participant progress against these plans which must be performed in compliance with applicable federal and state confidentiality laws.

(4) the procedure for obtaining authorization for continued treatment in special care;

(5) the procedure for rapid re-entry into special care of participants who relapse or have a crisis associated with chronic special care needs;

(6) provision for training of managed care and managed special care staff members to assure identification and treatment of participants requiring integrated health services and special care.

Section 360-11.6 Review process for managed care plan in managed care program which includes special care on more than incidental basis.

(a) The special care provisions of a managed care plan which includes special care for participants who require special care on more than an incidential basis must be submitted by the social services district in accordance with Section 360-10.7 of Subpart 360-10.

(b) Special care provisions of a managed care plan which includes special care for participants who require special care on more than an incidental basis require the approval of the Commissioner, in accordance with Section 360-10.7 of Subpart 360-10, and the RSCA.

(c) The RSCA must inform the department of its approval or disapproval of the special care provisions of such a managed care plan within 60 days after receiving such provisions for review.

(d) After being informed of the result of the RSCA's review, the department will notify the social services district of the approval or disapproval of the special care provisions of its managed care plan and whether an amendment to the special care provisions must be submitted by the district.

(e) The social services district must submit a required amendment to the special care provisions of its managed care plan within 90 days after receipt of written disapproval of such provisions from the department.

(f) The RSCA must inform the department of its approval or disapproval of the amendment to the special care provisions of a managed care plan within 30 days after receiving such amendment for review.

(g) After being informed of the result of the RSCA's review, the department will notify the social services district of the approval or disapproval of the amendment to the special care provisions of its managed care plan. The department's notification to the social services district will be made within 60 days after receipt of the required amendment from the district.

(h) The RSCA, in reviewing the special care provisions, or amendment to the special care provisions, of a managed care plan, may approve only a part of such provisions or amendment while disapproving the remainder if the approved part is capable of performance by the social services district and managed special care provider and would further the objectives of the MCP.

Section 360-11.7 Identification of MA recipients requiring special care on more than incidental basis.

(a) The social services district, in conjunction with the managed care provider and the local mental hygiene director, is responsible for identifying MA recipients and managed care participants who require special care on more than an incidental basis. The Department will distribute to social services district with an MCP, on a quarterly basis, a listing of MA recipients residing in such social services district who fulfill the criteria set forth in subdivision (c) of this section. For a period of 3 months from the effective date of the listing, the social services district may rely on the listing as conclusively determining that persons identified in the listing require special care on more than an incidental basis.

(b) An MA recipient who fulfills the criteria set forth in subdivision (c) of this section may choose to participate in a1 MCP if such MCP does not include the furnishing of special care to participants who require special care on more than an incidental basis.

(c) An MA recipient, or managed care participant requires special care on more than an incidental basis if the following conditions are satisfied:

(1) For mental health services for an MA recipient age 18 or older:

(i) the MA recipient who is not in a managed care program, is receiving or has, in the past 12 months, received services in a State hospital for the mentally ill or in an inpatient psychiatric unit licensed or certified by OMH, or at an outpatient facility operated or certified by OMH as a continuing day treatment program, a partial hospitalization program or an intensive psychiatric rehabilitative treatment program pursuant to 14 NYCRR Part 587 or as a continuing treatment or day treatment program pursuant to 14 NYCRR Part 585, or in excess of 10 patient and/or collateral visits at an outpatient facility operated or certified by OMH as a clinic treatment program pursuant to 14 NYCRR Parts 585 or 587; or

(ii) the MA recipient or managed care participant, while not satisfying the conditions of subparagraph (i), currently has a designated mental illness diagnosis and a dysfunction due to mental illness, or a designated mental illness diagnosis which has resulted in dysfunction due to acute symptomatology which requires medically supervised intervention to achieve stabilization and which, but for the availability of a partial hospitalization program, would necessitate admission to or continued stay in an inpatient hospital, and has been determined by the local mental hygiene director, through the use of a uniform, statewide assessment method approved by OMH, the Department of Health and the Department, to need services beyond those available to a participant from the managed care provider.

(2) For mental health services for an MA recipient up to age 18:

(i) the MA recipient who is not in a managed care program is receiving or has, in the past 12 months, received services in a State psychiatric center or inpatient psychiatric facility or residential treatment facility licensed by OMH, or at an outpatient facility operated, licensed or certified by OMH as a day treatment program pursuant to 14 NYCRR Part 585, or in excess of 10 patient and/or collateral visits at an outpatient facility operated or certified by OMH as a clinic treatment program pursuant to 14 NYCRR Parts 585 or 587; or

(ii) the MA recipient or managed care participant, while not satisfying the conditions of subparagraph (i), currently has a DSM-III-R designated mental illness diagnosis, has experienced substantial impairments in functioning due to emotional disturbance for at least the past 12 months on a continuous or intermittent basis or has exhibited severe symptoms within the past thirty days coupled with substantial impairments in functioning at the present time, and has been determined by the local mental hygiene director, through the use of a uniform, statewide assessment method approved by OMH, the Department of Health and the Department, to need services beyond those available to a participant from the managed care provider.

(3) For developmental disabilities services:

(i) the MA recipient who is not in a managed care program is receiving or has, in the past 12 months, received developmental disabilities services in accordance with an individual plan of care recognized by OMRDD or the State Education Department. This includes persons who have applied for developmental disability services and are having an individual plan of care developed for them. Developmental disabilities services, as referred to in this subparagraph (i), include: nutrition, recreation, self-care services, independent living, rehabilitation therapy, occupational therapy, physical therapy, speech therapy, rehabilitation counseling, personal care, nursing, psychiatry, psychology and social services; or

(ii) the MA recipient or managed care participant, While not satisfying the conditions of subparagraph (i), is determined by the local mental hygiene director, through the use of a uniform, statewide assessment method approved by OMRDD, the Department of Health and the Department, to need services beyond those available to a participant from the managed care provider.

(4) For Alcoholism and substance abuse services

(i) the MA recipient who is not in a managed care program is receiving or has in the past 12 months received: (a) alcohol and/or other drug medical detoxification in an alcohol or substance abuse detoxification unit or facility certified or licensed by DAAA/DSAS, an acute psychiatric unit licensed by OMH, or a medical/surgical unit in an Article 28 facility licensed by DOH; or (b) alcoholism inpatient rehabilitation services or substance abuse treatment and rehabilitation services in a facility certified or licensed by DAAA or DSAS, or (c) intensive outpatient alcoholism services scheduled for three or more visits per week in a DAAA certified outpatient clinic or outpatient rehabilitation program for alcohol-dependent individuals; or (d) treatment in a Methadone Maintenance Treatment Program (MMTP); or (e) in excess of 10 patient visits at an outpatient facility certified by DAAA/DSAS as a clinic.

(ii) the MA recipient who is a managed care participant shall be deemed to need special care on more than an incidental basis if the individual (a) satisfies the conditions of subparagraph (i) of this section, and has been determined to need services beyond those available from the managed care provider by the local mental hygiene director or other entity designated by the RSCA, in accordance with an assessment scale and method jointly approved by DAAA/DSAS, the Department of Health and the Department; or (b) is receiving care in a residential alcoholism or substance abuse facility wherein such facility is managing the primary care of the individual during the time of his or her residence; or (c) has sufficient dysfunction related to his or her alcohol abuse/dependence and/or substance abuse/dependence to need services beyond those available from the managed care provider, as determined by the local mental hygiene director or other entity designated by the RSCA, in accordance with an assessment scale and method jointly approved by DAAA/DSAS, the Department of Health and the Department. Such dysfunction may include, but is not limited to, the co-existence of a psychiatric disorder, and/or major medical conditions that are alcohol/substance related.

Section 360-11.8 Participant choice of managed special care provider.

(a) A managed care plan in an MCP which includes special care for participants who require special care on more than an incidental basis must offer such participants a choice of at least 3 managed special care providers if the general population of the social services district is over 350,000 persons.

(b) A participant in a mandatory MCP, which includes special care on more than an incidential basis, who has been determined to require special care on more than an incidential basis must select a managed special care provider within 21 days from the date the participant is notified in writing by the social services district of his or her need to select such a provider. A participant must be provided with information to make an informed choice of a managed special care provider. If a participant does not select a managed special care provider, the social services district will assign the participant to a managed special care provider selected from among all participating managed special care providers. The social services district will assign participants to managed special care providers on an equitable basis.

(c) If a participant who had a choice of managed special care providers wants to change his or her managed special care provider, the provisions of Sections 360-10.12 and 360-10.13 of Subpart 360-10 will determine whether such a change may be made.

360-11.9 Managed special care provider qualifications and standards.

(a) To be eligible to participate as a managed special care provider, a provider must possess all necessary approvals from the RSCA as provided by law, including but not limited to:

(1) approval by the local mental hygiene director and the Commissioner of Mental Health as a provider of mental health services satisfying the requirements of 14 NYCRR Part 512; or

(2) approval by the local mental hygiene director or other entity designated by the RSCA and OMRDD as a provider of developmental disabilities services; or

(3) approval by the local mental hygiene director or other entity designated by the RSCA as providing management of clinical care pursuant to DAAA/DSAS operating regulations.

(b) A provider eligible to participate as a managed special care provider must also:

(1) possess sufficient resources to assure delivery of quality special care to participants in an appropriate and timely manner;

(2) satisfy the requirements of subdivisions (g) through (i) of section 360-10.4 of Subpart 360-10 as applicable to the furnishing of special care;

(3) be enrolled as a provider in the MA program; and

(4) inform the participant's managed care provider of special care provided to the participant.