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¦ LOCAL COMMISSIONERS MEMORANDUM ¦
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DSS-4037EL (Rev. 9/89)

Transmittal No: 94 LCM-83

Date: July 12, 1994

Division: Health and Long Term Care

TO: Local District Commissioners

SUBJECT: Implementation of the Memorandum of Agreement for Special Care

ATTACHMENTS:
I. Revised Contract and Benefit Package (Available On-line)
II. Rate and Contract Expiration Dates (Available On-line)
III. Protocol (Available On-line)

As you know, the Memorandum of Agreement (MOA) for Special Care was signed in late January by the Commissioners of the State Departments of Social Services (SDSS), Health (SDOH), Mental Health (OMH), Mental Retardation and Developmental Disabilities (OMRDD), and the Office of Alcohol and Substance Abuse Services (OASAS). This agreement, as legislated by the Statewide Managed Care Act of 1991 defines "more than incidental" special care services and describes how those services will be provided within the framework of Medicaid managed care. The agreement specifies that the major components of the MOA will begin to be implemented by July 1,1994. In order to implement the agreement, there are many activities that are occurring such as contract changes, systems edits, rate development, refinement of quality assurance and monitoring specifications, and development of the protocol to assure appropriate linkages between managed care providers (mcp) and special care providers (scp). The purpose of this letter is to clarify certain provisions of the MOA and to bring you up to date on the status of implementation issues.

## I. SUMMARY OF MOA

There are three major components of the MOA which are of immediate concern to both local districts and the full risk managed care providers (Health Maintenance Organizations and Prepaid Health Services Plan) with which they contract:

The first component of the MOA will affect managed care provider rates and benefit packages. There are three areas which are impacted, as follows:

1) In all of the special care areas (mental health, mental retardation, developmental disabilities, alcohol and substance abuse) certain specialized services are being "carved-out" of the managed care providers' rates and benefit packages. These services are generally specialized in nature and furnished to individuals with long term disabilities.

2) Financial incentives, including changes in the stop-loss levels, enhanced rates, and higher reimbursement for services over stop-loss, have been developed. The primary purpose for these changes is to reinforce the State's expectation that managed care providers will establish formal affiliations with State certified special care providers for the provision of services which are not carved out of the managed care benefit package.

   The reduction of the stoploss level to 20 outpatient visits for mental health services and reimbursement changes for services provided after the stop loss threshold has been reached are also intended to encourage early assessment of special care service needs. It is expected that managed care providers will refer patients to OMH licensed providers when such early assessments indicate the need for more intensive mental health services rather than changing providers after the 20 visit threshold is met.

   Although the stoploss level for alcohol and substance abuse services has not been reduced, the same expectations regarding early assessment and coordination of care apply. The financial incentives for these services are incorporated directly into the managed care provider's rate. These incentives are expected to result in OASAS certified providers being included in managed care networks as well as increased use of these providers.

3) SSI enrollment will be suspended until such time as appropriate rate methodologies and health-only managed care programs can be developed for this category.

Another major component of the MOA deals with linkages between managed care providers and the special care providers which furnish the "carved-out" services described above. To assure that individuals who are enrolled with managed care providers and need these services are able to receive them in a timely and coordinated fashion, the MOA requires managed care and special care providers to adhere to a specific Linkage Protocol, being developed jointly by the Department and the special care agencies.

The third major component of the MOA deals with issues related to quality assurance and monitoring. The State Department of Health is taking the lead in these areas. Specific activities being undertaken include: development of assessment tools for managed care providers, review and assessment of the managed care providers' existing special care provider networks, review of

current reporting requirements and development of quality assurance monitoring protocols.

The following section describes the above in more detail, and provides specific guidelines regarding local district responsibilities for the implementation of the MOA.

## II. IMPLEMENTATION OF MOA

### Contract Changes

The MOA requires that the contract language and corresponding benefit package be changed to reflect the carved-out services as well as changes in stop-loss threshold, and reimbursement for mental health, alcohol and substance abuse services. The revised contract and benefit package with definitions of covered and carved-out services are included in Attachment I. The revised contract will be effective 7/1/94 for new managed care providers becoming operational on or after this date. For existing managed care providers, the new contract and corresponding carve-outs required by the MOA will become effective on the expiration date of capitation rates. This means that plans will continue to provide services according to the provisions of their current contract until their new rates become effective. In some cases, especially for 6/30/94 expirations, there will be retroactivity, due to the rate review and approval process. In other words, new rates will be approved later than 7/1/94, but will be effective retroactive to 7/1/94. SDSS and SDOH will make every effort to keep retroactivity at a minimum. A schedule of all contracts with rate and contract expiration dates is included in Attachment II. Also included in this Attachment is a letter from SDOH to all HMOs and PHSPs which contains a more detailed explanation of the financial incentive components of the MOA.

### Linkage Protocol

The Linkage Protocol sets forth the expectations of the State agencies for the relationships between managed care providers and special care providers of carved-out services. The Protocol is included as Attachment III. The Protocol is designed to assure that formal linkages and operational lines of communication are established between general managed care providers and special care providers of carved-out services. While all managed care providers will be required to sign the Protocol, not all special care providers will. Only those special care providers who furnish carved-out services will be required to sign the Protocol. Further, the Protocol is not a formal agreement between mcps and scps. By signing the Protocol, these providers are committing to adhere to the principles in the Protocol in their dealings with each other.

The Protocol focuses on three components: timely communication of information between special care providers and managed care providers; agreement by special care providers to use the managed care provider's network for necessary covered services; and the establishment of reasonable authorization and payment procedures by managed care providers for the timely approval of, and payment for, services covered by the managed care plan and appropriately ordered by special care providers.

Managed care providers and special care providers of carved-out services will be required to sign the Protocol. Some managed care and special care providers already have agreements or subcontracts in place or may want to establish such agreements that cover the same areas as the Protocol. Where they exist, the terms of these agreements will supersede those of the Protocol, as long as these agreements are consistent with Protocol requirements. These agreements will be reviewed by SDOH for consistency with the Protocol.

OMH, OASAS, and OMRDD, through their regional or local offices, will be assisting their providers in the signing of the Protocol. They will also make available to their providers listings of current managed care providers and those under development, by county. The SDOH will transmit the Protocol to the affected managed care providers and coordinate the collection of the signed Protocol. The other state agencies will be responsible for the distribution and collection of the Protocol for their special care providers.

The Department is requesting that the local district cooperate and participate in the process of implementing the Protocol. This will involve the facilitation and encouragement of communication between both groups, and may include activities such as provider/consumer group meetings and the exchange of information between the two groups of providers. The Department will implement a method to identify special care providers which have agreed to adhere to the Protocol.

The Department is requesting that the LDSS act as a resource and liaison to managed care providers with respect to the signing and implementation of the Protocol. Key to this role is the establishment of relationships and on-going communication with the local and regional counterparts of the other State agencies (eg: county mental hygiene agencies, regional OASAS and OMRDD offices). SDSS staff will be available for technical assistance in this process. It is anticipated that the local governmental units or designees of the other state agencies will actively participate in this process as well.

Quality Assurance/Monitoring

The SDOH has the lead in this area and is working on a number of areas including: development of uniform assessment tools for managed care providers, review of all managed care provider special care networks, development of QA performance measures, and reporting requirements. SDOH has been working with the other state agencies in all of these areas. Implementation of most of these MOA components is scheduled for later in the year (Fall, 1994).

Health Only/SSI Rates

The MOA requires that managed care providers which previously covered SSI individuals cease to enroll new SSI recipients. Currently enrolled SSI recipients have the option of remaining enrolled or disenrolling. SSI individuals will be able to enroll with managed care providers when SSI rates are developed by SDOH, and/or when health-only programs are established. Health-only programs will be "alternative" benefit packages

under which all special care services will be excluded (carved-out). It is expected that health-only programs for SSI recipients will become available by early 1995.

Another provision of the MOA addresses criteria for identification of individuals who require special care services on more than an incidental basis. This provision will not be implemented until health-only programs are available. Health-only programs for those who claim an exemption based on their previous experience with a special care provider will also become available in early 1995. Guidelines and requirements for the health-only option and exemption populations will be developed at a later date and conveyed to the local district. Not all managed care providers in all areas will elect to cover SSI or develop health-only programs. Therefore, local districts may want to consider developing or expanding partial capitation programs for the SSI and the exempt populations. It is recognized that some aspects of partial capitation programs are still under development; it is anticipated that these program models will be available in the near future, and local districts should consider these options in their planning process.

Managed Care Plans

Local districts will not be required to submit amendments to their initial managed care plans incorporating the provisions of the MOA. However, third year managed care plan amendments will be required to contain a description of the activities the local district has undertaken to implement the MOA.

Special Care Plans

Local districts and managed care providers who wish to develop managed special care programs will need to submit a special care plan. Managed special care programs are defined as managed care programs which provide the full range of managed care and special care services. The Statewide Managed Care Act contains specific requirements for such programs (eg: the availability of a managed special care provider for individuals who require special care services on more than an incidental basis; and standards and qualifications for the establishment of providers to become managed special care providers).

Requirements for fully integrated programs have not yet been developed. SDSS and the responsible special care agencies will develop guidelines and required characteristics defining such managed special care programs during the late 1994. Local districts wishing to implement such programs will need to develop a special care plan with the local mental hygiene director, the developmental disabilities services director, or other local designated entity, the community services board, and the managed care providers. The State special care agencies will participate in special care plan approval.

Demonstration/Pilot Programs

The Department has committed to work with the responsible State special care agencies (OMH, OASAS, OMRDD) to develop and implement managed special care programs on a demonstration or pilot basis. Several projects for OMRDD individuals are already under development, and the affected local districts have been involved in the process. The Department`s ability to develop local

pilot programs is limited, however, and if any local district is interested in pursuing local projects independently, these activities will be encouraged, with the Department providing assistance as resources permit. Proposals for such pilot programs should be developed at the local level and jointly submitted to the SDSS and the appropriate state special care agency by the local district and the local mental hygiene agency or other designated local special care agency.

Regulations

The Department intends to promulgate regulations for the special care provisions of Chapter 165 of the Laws of 1991 by the end of the year. In June of 1992, draft regulations were developed and disseminated via 92-LCM-87. These regulations were never finalized. With the signing of the MOA, the Department is now able to draft the necessary regulations to reflect the provisions of the legislation and the MOA. It is anticipated that these regulations will be placed in External Clearance in Fall, 1994, and local districts will have the opportunity to provide their input at that time.

Notification/Education

The local districts in conducting their existing contract review activities should work with their Medicaid managed care contractors in revisions to all marketing, informational and educational materials to reflect all changes in this LCM which impact on Medicaid eligible enrollees and potential enrollees. The Department and SDOH will assist in this process through their review functions, and will provide technical assistance in the development of appropriate materials.

The contact person for this LCM is Anne Smith, (518) 473-0577, user I.D. AY9500.

Sue Kelly
Deputy Commissioner
Division of Health & Long Term Care

ATTACHMENT I
(contract revisions)
Page 1 of 16

REQUIRED CONTRACT REVISIONS (SPECIAL CARE)

All new and existing Medicaid Managed Care contracts must incorporate the following revisions and/or additions to the body of the contract as well as the Benefit Package Appendix (attached) beginning July 1, 1994. For existing contracts, amendments must be executed when the Contractor's current annual rate period expires, beginning with June 30, 1994 rate expirations.

o Section 1 DEFINITIONS: The following replaces the definition of "Stop-loss" (Section 1.26 of March 1988 State Model Contract):

1.26 "Stop-loss" means the dollar amount, inpatient days and outpatient visit thresholds for mental health, alcohol, and drug treatment services, above which the Contractor is no longer financially responsible for the cost of care that an Enrollee receives, as set forth in Section 3A of this Agreement.

o Section 3 COMPENSATION/CAPITATION RATE: The following replaces Section 3.1 and 3.2 (of March 1988 State Model Contract):

3.1(a) Compensation to the Contractor shall consist of monthly capitation payments for each Enrollee as agreed to by SDOH and the Contractor and as approved by SDSS and the State Division of Budget. The Contractor shall submit to SDOH, Bureau of Community Health Insurance and Finance Systems (BCHIFS), an Operating Plan/Premium Proposal in the format and timeframes specified by SDOH, BCHIFS. The actuarial methodology for computation of the maximum allowable rates, as determined by SDOH, is set forth in Appendix B of this Agreement, attached hereto and incorporated herein. Monthly capitation payments to the Contractor, for a defined scope of services to be furnished to a defined number of Enrollees, for providing the services contained in the Benefit Package described in this Agreement may not exceed the cost of providing those services on a fee-for-service basis to an actuarially equivalent, non-enrolled population group as determined by SDOH. The monthly Capitation Rates as agreed to by SDOH and the Contractor shall be deemed incorporated into this Agreement without further action by the parties, upon approval by SDSS and the State Division of the Budget.

3.1 (b) The Contractor will receive an enhancement to or reduction in its premium rates based on financial information that the Contractor submits to SDOH/BCHIFS in its Operating Plan/Premium Proposal about providers certified by the Office of Alcholism and Substance Abuse Services (OASAS). The methodology and procedure for submission of this information are included in the instructions for preparation of the Operating Plan/Premium Proposal.

New Section 3A STOP-LOSS: The following Replaces Section 3.11 (of March 1988 State Model Contract):

3A.1 The Contractor shall be compensated for all services in the Benefit Package provided to the Enrollee that are over the amounts set forth in Sections 3A.2, 3A.3, 3A.4, and 3A.5 of this Agreement. These payments, called "Stop-loss" payments, shall continue until the end of the calendar year period, or until the Enrollee disenrolls (whichever comes first). Procedures for claiming and processing Stop-loss payments are established by SDSS and SDOH and may be obtained by contacting SDOH, Office of Health Systems Management, Bureau of Medicaid Management Information Systems, 121 State Street, 4th Floor, New York 12207, Attention: Stop-loss.

3A.2 If the medical expenses incurred by the Contractor for an individual Enrollee during any calendar year period reach _____, the Contractor shall be compensated for services in excess of this amount on the basis of the Contractor's fee schedule.

3A.3 If an Enrollee has more than twenty (20) mental health outpatient visits during the calendar year, the Contractor shall be compensated for additional visits as follows:

a. The Contractor will receive the Medicaid rate for services provided by a provider licensed by the State Office of Mental Health ("SOMH").

b. If the provider is not licensed by SOMH, the Contractor will receive

(1) twenty percent (20%) less than the relevant Contractor's fee for visits twenty-one (21) through twenty-five (25) and

(2) thirty percent (30%) less than the relevant Contractor's fee for visits in excess of twenty-five (25).

3A.4 For Enrollees with more than sixty (60) alcohol and drug treatment outpatient visits during the calendar year, the Contractor will be compensated for services in excess of this amount on the basis of the Contractor's fee schedule.

3A.5 For Enrollees with more than an inclusive total of 30 days of inpatient mental health, alcohol and drug treatment services in a voluntary, municipal, licensed proprietary hospital or state operated facility, the Contractor will be compensated for services in excess of this amount on the basis of the Contractor's fee schedule.

o Section 5 PERSONS ELIGIBLE FOR ENROLLMENT: The following replaces Section 5.1 (of March 1988 State Model Contract):

5.1 (a) Except as specified in Section 6.1 below, and except for persons whose eligibility for Medicaid is governed by 18 NYCRR

Section 360-4.8 (c)(i)("reduction of excess income"), all persons in the following aid categories, indicated by an "X", who reside in the Service Area shall be eligible for enrollment in the Contractor's plan:

____ AFDC (Aid to Families with Dependent Children)

____ HR (Home Relief)

____ MA-AFDC Related (MA-Only)

____ MA-HR Related (MA-Only)

(b) Only persons in the aid categories specified in 5.1 (a), that are indicated by an "X" shall be enrolled in the Contractor's plan. Notwithstanding the foregoing, if an Eligible Person is enrolled in the Contractor's plan, and his/her aid category changes to any of the aid categories listed below, that person shall continue to be enrolled in the Contractor's plan.

(List those aid categories that you will not enroll, but agree to keep enrolled in your plan if an Enrollee transitions to such aid category).

o Section 6 ENROLLMENT EXCLUSIONS: The following renames and replaces Section 6 (of March 1988 State Model Contract) in its entirety:

6.1 Enrollment Exclusions are set forth in the Benefit Package Appendix _____ of this Agreement.

6.2 The Contractor and LDSS shall establish adequate screening procedures for the Contractor to use in identification of individuals subject to enrollment exclusions to ensure that these persons are not enrolled in the Contractor's plan.

# MODEL HMO/PHSP MEDICAID BENEFIT PACKAGE, NON-COVERED SERVICES, AND ENROLLMENT EXCLUSIONS

Introduction: The categories of services (e.g.: Inpatient Hospital, Physician Services, etc.) and their descriptions are consistent with the Medicaid program and the calculation of the HMO capitation rates. Therefore, plans and counties should not alter the descriptions of service categories. However, through state/local/plan rate and benefit discussions, a service category listed in the "Benefit Package" section may be moved to the "Non-Covered" section, if the plan does not have a delivery system for that service category (e.g.: optical). Each plan/county Benefit Package appendix to the Agreement should be based on this Model and the above parameters.

* = New revisions to this Model Benefit Package based on the Special Care Memorandum of Agreement between NYS DSS, OASAS, OMH, OMRDD, and SDOH are identified with an asterisk (*).

APPENDIX

[INSERT COUNTY LDSS]/[INSERT PLAN]
BENEFIT PACKAGE, NON-COVERED SERVICES,
AND ENROLLMENT EXCLUSIONS

The health care services listed as "Benefit Package Services" shall be provided by the Contractor to enrollees as benefits rendered under the terms of this Agreement. The service descriptions utilized herein are in summary form. The full description and scope of the services specified herein are established by the Medical Assistance Program as set forth in the applicable MMIS provider manual. It is understood that Contractor's delivery of such services is dependent upon Contractor's model (I.P.A., staff, network) and Contractor specific delivery sites.

With the exception of emergency services (as defined in Section 10 of the Agreement), all care provided by the Contractor, pursuant to this Agreement must be provided, arranged, or authorized by the Contractor or its Participating Practitioners.

BENEFIT PACKAGE/COVERED SERVICES

Inpatient Hospital: Inpatient hospital services are those items and services, provided under the direction of a physician or dentist, ordinarily furnished by the hospital for the care and treatment of inpatients. Among other services, inpatient hospital services encompass a full range of necessary diagnostic and therapeutic care including surgical medical, nursing, radiological and rehabilitative services.

Physician Services: Services provided in an office, home, or hospital. Physician services include the full range of preventive, primary care medical services and physician specialty services.

In addition to the full range of medical services, the following benefits are also included:

- certain specified laboratory procedures performed in the office during the course of treatment (refer to laboratory services);

- family planning health services including diagnosis, treatment and related counseling furnished under the supervision of a physician;

- Child/Teen Health Plan (C/THP) services which are comprehensive primary health care services provided to children under age 21.

Nurse Practitioner Services: The practice of a nurse practitioner may include preventive services, the diagnosis of illness and physical conditions, and the performance of therapeutic and corrective measures. A nurse practitioner must have a collaborative agreement and practice protocols with a licensed physician in accordance with the requirements of the Department of Education.

Outpatient Services (Clinic): Outpatient services are provided through ambulatory care facilities. Ambulatory care facilities include Hospital Outpatient Departments (OPD), Diagnostic and Treatment Centers (Free Standing Clinics) and Emergency Rooms. Hospital Outpatient Department and Diagnostic and Treatment (D&T) centers may provide those necessary medical, surgical, and rehabilitative services and items authorized by their operating certificates. Outpatient services (clinic) also include mental health, alcohol, drug, C/THP and family planning services provided by ambulatory care facilities.

Ordered Ambulatory Services (Preferred Ambulatory): Hospital OPDs and D&T centers may perform ordered ambulatory services. The purpose of ordered ambulatory services is to make available to the private practitioner those services needed to complement the provision of ambulatory care in his/her office. Examples are: diagnostic testing, radiology, and lab work.

Laboratory Services: All laboratory testing sites providing services under this contract have either a Clinical Laboratory Improvement Act (CLIA) certificate of waiver or a certificate of registration along with a CLIA identification number. Those laboratories with certificates of waiver will provide only the eight types of tests permitted under the terms of their waiver. Laboratories with certificates of registration may perform a full range of laboratory tests.

Radiology Services: Are defined as the provision of diagnostic radiology, diagnostic ultrasound, nuclear medicine, radiation oncology, and magnetic resonance imaging (MRI). These services may be performed in a physician's office or in a hospital OPD or a D&T center upon the order of a qualified physician.

Certified Home Health Agency Services: Services which are provided by a certified home health agency to recipients in their homes. These services may include nursing, home health aide services, medical supplies, equipment and appliances, physical therapy, speech/language pathology, occupational therapy, social work services or nutritional services. Services must be medically necessary pursuant to an established care plan. Personal care tasks performed by a home health aide in connection with a certified home health care agency visit, and pursuant to an established care plan, are covered.

Nursing Services: These may be provided to individuals in their homes or in the home of a responsible person. Private duty nursing care may also be provided in an acute care hospital on the recommendation of the patient's attending physician when the patient is in need of individual and continuous care beyond that which is available from the staff of the acute care hospital, including the hospital's critical care units.

Nursing services include nursing care rendered directly to the individual and, when services are provided in the patient's home, instructions to his/her family in the procedures necessary for the patient's treatment. All nursing services must be in accordance with and conform to the ordering physician's treatment plan as it is outlined in his/her written recommendation.

Podiatry Services: Services include routine foot care products only when the enrollee's physical condition poses a hazard due to the presence of localized illness, injury or symptoms involving the foot, or when they are preformed as a necessary and integral part of otherwise covered services such as the diagnosis and treatment of diabetes, ulcers, and infections.

Medicaid coverage of podiatry excludes routine hygienic care of the feet, the treatment of corns and calluses, the trimming of nails, and other hygienic care such as cleaning or soaking feet, in the absence of pathological condition.

Therapy: Occupational Therapists, Physical Therapists and Speech-Language Pathologists: Rehabilitation services are rendered for the purpose of maximum reduction of physical or mental disability and restoration of the recipient to his or her best functional level. Rehabilitation services include care and services rendered by physical therapists, speech-language pathologists and occupational therapists.

Durable Medical Equipment (DME) including Medical/Surgical Supplies, Prosthetic Appliances, Orthotic Appliances, and Hearing Aid Services:

- Durable Medical Equipment - are devices and equipment, other than prosthetic or orthotic appliances, which have been ordered by a qualified practitioner in the treatment of a specific medical condition.

- Medical/Surgical Supplies - are items for health use other than drugs, prosthetic or orthotic appliances, or durable medical equipment which have been ordered by a qualified practitioner in the treatment of a specific medical condition and which are: consumable, non-reusable, disposable, for a specific rather than incidental purpose, and generally have no salvageable value.

- Prosthetic Appliances and Devices - are those appliances and devices, other than artificial eyes, ordered for a recipient by a qualified practitioner which replace any missing part of the body.

- Orthotic Appliances and Devices - are those appliances and devices, including prescription footwear ordered for a recipient by a qualified practitioner which are used for the purpose of supporting a weak or deformed body part or to restrict or eliminate motion in a diseased or injured part of the body.

- Hearing Aid Services - include hearing aid devices furnished to alleviate disability caused by the loss or impairment of hearing; it also includes hearing aid repairs and the replacement of accessories when necessary to maintain a recipient's hearing aid in functioning order.

  Note: If DME is not included in the benefit package, there are special requirements associated with the provision of hearing aids to Medicaid recipients under age 21. These requirements are outlined in the New York State Medicaid Management Information Systems (MMIS) Hearing Aid Provider Manual.

Nurse-Midwife Services: These services apply to the health care management of mothers and newborns throughout the maternity cycle (pregnancy, labor, the performance of delivery, and the immediate [six weeks] postpartum period), as well as primary preventive reproductive health care of essentially healthy women. The care may be provided in a hospital on an inpatient basis or outpatient basis, in a diagnosis and treatment center, in the office of the nurse-midwife or collaborating physician, or in the recipient's home as appropriate. The nurse-midwife must be licensed in accordance with current N.Y.S. rules and regulations pertaining to professional midwifery practice. According to Insurance and Health Law, Contractor must include nurse-midwives in their provider network.

Pharmacy Services: Services include drugs which appear on the "New York State List of Medicaid Reimbursable Drugs: Non-Prescription Drugs and Prescription Drugs" as well as supplies which appear on the list of "Allowable Medical and Surgical Supplies". Pharmaceuticals consist of both over-the-counter and prescription drugs and supplies.

Transportation Services: These include ambulance, ambulette, livery services, and public transportation to transport clients to necessary medical care. Also permitted is the cost of an attendant to accompany the patient, if medically necessary.

Note: Transportation reimbursement and authorization procedures vary by local social services district. Details of coverage, authorization, and payment between the Contractor and LDSS should be specified in this section.

Eye Care: Optical/Ophthalmic Services: Eye care includes the services of an optometrist and an ophthalmic dispenser. The optometrist may perform an eye examination to detect visual defects and eye disease as necessary or as required by the recipient's condition. An ophthalmic dispenser fills the prescription of an optometrist or ophthalmologist and supplies eyeglasses or other vision aids upon the order of a qualified practitioner.

Dental Services: Services include only essential preventive, prophylactic, diagnostic, restorative, endodontic, surgical, adjunctive, and orthodontic services.

Note: Plan's who cover dental may propose "orthodontic" as a non-covered service with the approval of the local Department of Social Services, SDSS, and SDOH.

* Outpatient Mental Health Services:

With the exception of the mental health services listed in the Non-Covered and Enrollment Exclusions section of this Appendix, outpatient mental health services are covered in full. (See Section 3A of this Agreement for the financial risk limitations for Contractor covered outpatient mental health services.)

* Outpatient Alcohol and Drug Treatment Services:

  With the exception of alcohol and drug treatment services listed in the Non-Covered and Enrollment Exclusions section of this Appendix, outpatient alcohol and drug treatment services are covered in full. (See Section 3A of this Agreement for the financial risk limitations for Contractor covered outpatient alcohol and drug treatment services.)

* Inpatient Mental Health, Alcohol and Drug Treatment Services:

  Inpatient mental health, alcohol and drug treatment services are covered in full. (See Section 3A of the Agreement for the financial risk limitations for Contractor covered inpatient mental health, alcohol and drug treatment services.)

NON-COVERED SERVICES

The following Medicaid services are not covered by the Contractor. Enrollees may obtain such services directly from Medicaid providers who, in turn, shall bill MMIS directly for payment. The person remains enrolled in Contractor's plan.

Alcohol and Substance Abuse Services:

* Methadone Maintenance Treatment Program (MMTP)

  Consists of drug detoxification, drug dependency counseling, and rehabilitation services which include chemical management of the patient with methadone. Facilities that provide methadone maintenance treatment do so as their principal mission and are certified by the Office of Alcohol and Substance Abuse Services under 14 NYCRR, Part 1040.1.

* Substance Abuse Services Provided By 1035 Facilities

  These programs provide medically supervised ambulatory substance abuse treatment that focuses on medical oversight of clients with health conditions in addition to their substance abuse. Individual and group counseling for the primary client and his/her significant others, psychological evaluations, and educational, vocational, and social services are made available to each client to help the client address and resolve the substance abuse problem. These facilities are certified by OASAS under 14 NYCRR, Part 1035.

* Outpatient Alcoholism Rehabilitation Services

  Outpatient alcoholism rehabilitation programs provide intensive full or half-day services to meet the needs of a specific target population. When appropriate, they may be operated independently of outpatient clinics, if they remain affiliated with an accessible clinic program. Most outpatient rehabilitation programs will have a separate, identifiable and specially designed environment and

specific target population of chronic alcoholic persons who need a range of services which are different from those typically provided in an alcoholism outpatient clinic. These services are certified by OASAS under 14 NYCRR, Part 372.3.

Mental Health Services:

* Intensive Psychiatric Rehabilitation Treatment Programs (IPRT)

A time limited 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 rehabilitative technologies to overcome functional disabilities. IPRT services are certified by OMH under 14 NYCRR, Part 587.12.

* Day Treatment

A combination of diagnostic, treatment, and rehabilitative procedures which, through supervised and planned activities and extensive client-staff interaction, provides the services of the clinic treatment program, as well as social training, task and skill training and socialization activities. Service is expected to be of six months duration. These services are certified by OMH under 14 NYCRR, Part 585.11.

* Continuing Day Treatment

Provides treatment designed to maintain or enhance current levels of functioning and skills, maintain community living, and develop self-awareness and self-esteem. Includes: assessment and treatment planning; discharge planning; medication therapy medication education; case management; health screening and referral; rehabilitative readiness development; psychiatric rehabilitative readiness determination and referral; and symptom management. These services are certied by OMH under 14 NYCRR, Part 587.10.

* Intensive Case Management (ICM)

The target population consists of individuals who are seriously and chronically mentally ill, require intensive, personal and proactive intervention to help them obtain those services which will permit functioning in the community and either have symptomology which is difficult to treat in the existing mental health care system or are unwilling or unable to adapt to the existing mental health care system.

Please note: See generic definition of Comprehensive Medicaid Case Management (CMCM) under OTHER NON-COVERED SERVICES.

* Partial Hospitalization

  Provides active treatment designed to stabilize and ameliorate acute systems, serves as an alternative to inpatient hospitalization, or reduces the length of a hospital stay within a medically supervised program by providing the following: assessment and treatment planning; health screening and referral; symptom management; medication therapy; medication education; verbal therapy; case management; psychiatric rehabilitative readiness determination and referral; crisis intervention. These services are certified by OMH under 14 NYCRR, Part 587.22.

* Rehabilitation Services Provided to Residents of OMH Licensed Community Residences (CRs) and Family Based Treatment Programs, As Follows:

  o OMH Licensed CRs:

    Rehabilitative services in community residences are interventions, therapies and activities which are medically therapeutic and remedial in nature, and are medically necessary for the maximum reduction of functional and adaptive behavior deficits associated with the person's mental illness.

  o Family-based Treatment:

    Rehabilitative services in family-based treatment programs are intended to provide treatment to seriously emotionally disturbed children and youth to promote their successful functioning and integration into the natural family, community, school or independent living situations. Such services are provided in consideration of a child's developmental stage. Those children determined eligible for admission are placed in surrogate family homes for care and treatment.

Both CR and FBT services are certified by OMH under 14 NYCRR, Part 586.3.

* Services For Children With Serious Emotional Disturbance (SED):

  These are services provided to children and adolescents with serious emotional disturbance that will be provided by certain designated OMH clinics. Children meeting the SED definition must have certain DSM-III diagnoses, as well as meeting other at risk or functional impairment criteria.

Mental Retardation and Developmental Disabilities Services:

* Habilitation Services Provided by Article 16-Clinic Treatment Facilities or Article 28 Facilities

These services to persons with developmental disabilities include medical or remedial services recommended by a physician or other licensed practitioner of the healing arts for a maximum reduction of the effects of physical or mental disability and restoration of the person to his or her best possible functional level. It also includes the fitting, training, and modification of assistive devices by licensed practitioners or trained others under their direct supervision. Such services are designed to ameliorate or limit the disabling condition and to allow the person to remain in, or move to, the least restrictive residential and/or day setting. These services are certified by OMRDD under 14 NYCRR, Part 679.

* Day Treatment

A planned combination of diagnostic, treatment and rehabilitation services provided to developmentally disabled individuals in need of a broad range of services, but who do not need intensive 24 hour care and medical supervision. The services provided as identified in the comprehensive assessment may include nutrition, recreation self-care, independent living, therapies, nursing, and transportation services. These services are generally provided in ICF or comparable setting. These services are certified by OMRDD under 14 NYCRR, Part 690.99.

* Comprehensive Medicaid Case Management (OMRDD)

The target population consists of individuals who are developmentally disabled, in need of ongoing and comprehensive rather than incidental case management and reside in OMRDD Certified Family Care Homes, Community Residences, live independently or with family or reside in residential facilities certified by a state agency other than OMRDD and are referred by the residential facility, or its supervising or certifying agency.

Please note: See generic definition of Comprehensive Medicaid Case Management (CMCM) under OTHER NON-COVERED SERVICES.

* Home And Community Based Services Waivers

The Home and Community Based Waiver Program serves developmentally disabled persons who would otherwise be admitted to an ICF/MR if waivered services were not provided. The services provided include case management, respite, medical social counseling, nutrition counseling, respiratory therapy, and home adaptations. These services are authorized pursuant to a 1915 (b) waiver from DHHS.

* Services Provided Through The Care At Home Program (OMRDD)

"Care At Home" waivers serve children who would not be eligible for Medicaid due to parents' income and resources and who are physically disabled according to SSI criteria and who are determined capable of being cared for at home if provided additional waivered services. These services are authorized pursuant to a 1915 (b) waiver from DHHS.

OTHER NON-COVERED SERVICES:

Personal Care Agency Services: Services rendered by a personal care agency which are approved by the local social services district are not covered under the Contractor's benefit package. Should it be medically necessary for the primary care physician (PCP) to order personal care agency services, the PCP (or the Contractor on the physician's behalf) must first contact the recipient's local social services district contact person for personal care. The district will determine the applicant's need for personal care agency services and coordinate with the personal care agency a plan of care.

The Early Intervention Program (EIP): This program provides early intervention services to certain children, from birth through two years, who have a developmental delay or a diagnosed physical or mental condition that has a high probability of resulting in developmental delay. All child health care providers may act as primary referral sources. As such, all managed care providers must refer infants and toddlers to the locally designated Early Intervention agency in their area. In most municipalities, the county health department is the designated agency,except: New York City - the Department of Health, Mental Retardation and Alcoholism Services; Erie County - the Department of Youth Services; Jefferson County - the Office of Community Services; and Ulster County - the Department of Social Services.

The local early intervention agency will designate a service coordinator who will coordinate the screening, evaluation and assessment process to identify a child's unique needs, and will be responsible for coordinating all necessary early intervention services. This individual will serve as the primary point of contact to assist parents in obtaining the services and/or assistance they need. The service coordinator will also coordinate the development of the individualized family services plan (IFSP), a written plan for providing early intervention services.

Early intervention services provided to this eligible population are categorized as Non-Covered since costs related to these services were not included in fee-for-service capitation calculations. These services will stay categorized as Non-Covered at least until such time as historical data becomes available. These services, which are designed to meet the developmental needs of the child and the needs of the family related to enhancing the child's development, will be identified on MMIS by unique rate codes by which only the designated early intervention agency can claim reimbursement. Contractor covered and authorized services will continue to be provided by the Contractor. Consequently, the Contractor will be expected to refer any enrolled child suspected of having a developmental delay to the locally designated early intervention agency in their area and participate in the development of the child's IFSP. Contractor's participation in the development of the IFSP is necessary in order to coordinate the provision of early intervention services and services covered by the Contractor.

Additionally, the locally designated early intervention agencies will be instructed on how to identify a managed care recipient and the need to contact the Contractor to coordinate service provision.

Preschool Supportive Health Services: The State Departments of Social Services and Education have developed and implemented the Preschool Supportive Health Services Program (PSHSP) to assist counties and New York City in obtaining third party reimbursement for certain educationally related medical services provided by approved preschool special education programs for young children with disabilities. The Committee on Preschool Special Education in each school district is responsible for the development of an individualized education program (IEP) for each child evaluated in need of special education and medically related health services.

The following PSHSP services, i.e., physical therapy, occupational therapy and speech therapy, rendered to children 3 through 4 years of age in conjunction with an approved IEP are categorized as Non-Covered since the costs related to these services were not included previously in fee-for-service capitation calculations. As other medically related PSHSP services receive federal approval, the list of non-covered services will be expanded.

The PSHSP services will be identified on MMIS by unique rate codes which only counties and New York City can claim reimbursement. Contractor covered and authorized services will continue to be provided by the Contractor.

School Supportive Health Services: The State Departments of Social Services and Education have developed and implemented the School Supportive Health Services Program (SSHSP) to assist school districts in obtaining third party reimbursement for certain educationally related medical services provided by approved special education programs for children with disabilities. The Committee on Special Education in each school district is responsible for the development of an individualized education program (IEP) for each child evaluated in need of special education and medically related services.

The following SSHSP services, i.e., physical therapy, occupational therapy and speech therapy, rendered to children 5-21 years in conjunction with an approved IEP are categorized as Non-Covered since the costs related to these services were not included previously in fee-for-service capitation calculations. As other medically related SSHSP services receive federal approval, the list of Non-Covered services will be expanded.

The SSHSP services will be identified on MMIS by unique rate codes which only school districts can claim Medicaid reimbursement. Contractor covered and authorized services will continue to be provided by the Contractor.

Comprehensive Medicaid Case Management (CMCM): A program which provides "social work" case management referral services to a targeted population (e.g.: pregnant teens, mentally ill). A CMCM case manager will assist a client in accessing necessary services in accordance with goals contained in a written case management plan. CMCM programs do not provide services directly, but refers to a wide range of service

providers. Some of these services are: medical, social, psycho-social, education, employment, financial, and mental health. CMCM referral to community service agencies and/or medical providers requires the case manager to work out a mutually agreeable case coordination approach with the agency/medical provider. Consequently, if an enrollee of the Contractor is participating in a CMCM program, the Contractor should work collaboratively with the CMCM case manager to coordinate the provision of services covered by the Contractor. CMCM programs will be instructed on how to identify a managed care recipient on EMEVS and informed on the need to contact the Contractor to coordinate service provision.

ENROLLMENT EXCLUSIONS

Persons in receipt of the following Medicaid services shall be deemed ineligible for enrollment in the Contractor's plan. If an enrolled member requires receipt of such services, he/she shall be disenrolled from the Contractor's plan, except as otherwise provided below:

1. Residential Health Care Facilities (RHCF) - Person is not expected to return home.

2. The Long Term Home Health Care Program (Nursing Home Without Walls Program/Lombardi Program)

3. Voluntary Child Caring Agency

4. Residential Treatment Facility for Children or Youth

5. Hospice

6. Office of Mental Health (OMH) State Institutions: Persons residing in OMH State institutions shall be deemed ineligible for enrollment in the Contractor's plan.

7. Inpatient Services in a Veterans Administration (V.A.) Facility is not reimbursed by Medicaid and therefore, the Contractor is not responsible for payment if an enrollee seeks V.A. services without Contractor authorization. An enrollee should be disenrolled from the Contractor's plan only if the enrollee is not expected to return home from a V.A. facility.

8. The Physically Handicapped Children Program (PHCP) To date, most County/Plan contracts exclude PHCP. However, the scope of services provided through the PHCP differ by county. Therefore, LDSS' may wish to explore exceptions to this exclusion based upon the specific services provided by the local PHCP.

9. Already enrolled in a Health Maintenance Organization or Partial Capitation Program authorized by SDSS or SDOH.

10. Restricted under the Recipient Restriction Program.

11. Has a disability, chronic infirmity or condition, receives certified home health agency services, and has medical needs which are more appropriately met outside a managed care plan, as determined by the social services district, in consultation with the recipient's certified home health services provider.

* 12. SSI: Individuals eligible for and receiving SSI benefits, unless covered under Section 5.1 (b).

* 13. Therapeutic Communities (Drug-Free Residential Programs) (OASAS)

Therapeutic Communities are substance abuse programs in which drug free substance abuse treatment and living accommodations are provided to substance abusers and substance dependent persons. Persons residing in therapeutic communities receive intensive counseling and comprehensive rehabilitative services such as vocational, educational, and legal. Residents usually receive their health care services from affiliated providers. TC's are certified by OASAS under 14 NYCRR, Part 1030.1.

* 14. Community Residence Alcoholism Treatment (OASAS)

Community Residence means a residential facility with cooperative relations to a comprehensive delivery system for persons suffering from alcoholism. CRs include halfway houses, recovery homes and supportive living facilities, and residential chemical dependency programs for youth (Part 382). Medicaid recipients residing in OASAS certified community residences receiving alcoholism treatment services would be eligible to join managed care programs for health care only. These services are certified by OASAS under 14 NYCRR, Part 375.3.

Note: Certain Non-Covered Services and Enrollment Exclusions (e.g.: personal care, RHCF) may, at the Contractor's option, be provided when an enrollee's primary care physician or the medical director of the Contractor determines that such services would expedite or facilitate the early discharge from an acute care hospital. The Contractor remains responsible for managing the enrollee's care. The cost of such services under this arrangement shall be borne by the Contractor.

* = New Revisions To This Model Benefit Package, Based On The Special Care Memorandum of Agreement Between NYS DSS, OASAS, OMH, OMRDD, and SDOH, are identified with an asterisk (*).

ATTACHMENT I
(contract revisions)
ATTACHMENT II

RATE AND CONTRACT EXPIRATIONS DATES



| PLAN | COUNTY | CURRENT CONTRACT DATE | RATE DATE |
|---|---|---|---|
| BlueChoice/GVGHA | Monroe | 1/1/94-12/31/94 | 1/1/94-12/31/94 |
| Bronx Health Plan | Bronx | 1/1/92-12/31/95 | 1/1/94-12/31/94 |
| CDPHP | Albany | 12/1/92-12/31/96 | 1/1/94-12/31/94 |
| CDPHP | Columbia | 1/1/94-12/31/94 | 1/1/94-12/31/94 |
| CDPHP | Greene | 1/1/94-12/31/94 | 1/1/94-12/31/94 |
| CDPHP | Rensselaer | 1/1/94-12/31/94 | 1/1/94-12/31/94 |
| CDPHP | Saratoga | 6/1/93-12/31/94 | 1/1/94-12/31/94 |
| CDPHP | Schenectady | 1/1/94-12/31/94 | 1/1/94-12/31/94 |
| Comprecare | Warren | 1/1/94-12/31/94 | 1/1/94-12/31/94 |
| Comprecare | Washington | 1/1/94-12/31/94 | 1/1/94-12/31/94 |
| Healthnet | Bronx | 1/1/93-12/31/95 | 1/1/94-12/31/94 |
| Healthnet | Brooklyn | 1/1/93-12/31/95 | 1/1/94-12/31/94 |
| HMO-CNY | Onondaga | 7/1/93-12/31/94 | 1/1/94-12/31/94 |
| HSMC | Oneida | 1/1/94-12/31/94 | 1/1/94-12/31/94 |
| HSMC | Onondaga | 1/1/93-12/31/94 | 1/1/94-12/31/94 |
| IHA/HV | Orange | 8/1/93-12/31/93 | 1/1/94-12/31/94 |
| MHSNY | Brooklyn | 8/1/93-12/31/95 | 1/1/94-12/31/94 |
| MVP | Dutchess | 1/1/94-12/31/94 | 1/1/94-12/31/94 |
| MVP | Ulster | | 1/1/94-12/31/94 |
| MVP | Clinton | 12/1/93-12/31/94 | 1/1/94-12/31/94 |
| MVP | Delaware | 1/1/94-12/31/94 | 1/1/94-12/31/94 |
| MVP | Fulton | 1/1/94-12/31/94 | 1/1/94-12/31/94 |
| MVP | Montgomery | 1/1/94-12/31/94 | 1/1/94-12/31/94 |
| MVP | Rensselaer | 1/1/94-12/31/94 | 1/1/94-12/31/94 |
| MVP | Saratoga | | 1/1/94-12/31/94 |
| MVP | Schenectady | 1/1/94-12/31/94 | 1/1/94-12/31/94 |

| PLAN | COUNTY | CURRENT CONTRACT DATE | RATE DATE |
|---|---|---|---|
| MVP | Warren | 10/1/93-12/31/94 | 1/1/94-12/31/94 |
| MVP | Washington | | 1/1/94-12/31/94 |
| MVP | Chenago | | 1/1/94-12/31/94 |
| MVP | Franklin | 1/1/94-12/31/94 | 1/1/94-12/31/94 |
| MVP | Hamilton | | 1/1/94-12/31/94 |
| MVP | Herkimer | 1/1/94-12/31/94 | 1/1/94-12/31/94 |
| MVP | Madison | 1/1/94-12/31/95 | 1/1/94-12/31/94 |
| MVP | Oneida | 1/1/94-12/31/94 | 1/1/94-12/31/94 |
| MVP | Otsego | 1/1/94-12/31/94 | 1/1/94-12/31/94 |
| MVP | St. Lawrence | 4/1/94-12/31/95 | 1/1/94-12/31/94 |
| Preferred Care | Monroe | 1/1/94-12/31/94 | 1/1/94-12/31/94 |
| Sanus | Nassau | 1/1/93-12/31/93 | 1/1/94-12/31/94 |
| Sanus | Suffolk | 1/1/93-6/30/93 | 1/1/94-12/31/94 |
| US Healthcare | Nassau | 7/1/93-12/31/94 | 1/1/94-12/31/94 |
| US Healthcare | Suffolk | 7/1/93-6/30/94 | 1/1/94-12/31/94 |
| US Healthcare | Orange | | 1/1/94-12/31/94 |
| US Healthcare | Putnam | 12/1/93-12/31/94 | 1/1/94-12/31/94 |
| US Healthcare | Rockland | 1/1/94-12/31/94 | 1/1/94-12/31/94 |
| US Healthcare | Bronx | 1/1/93-12/31/95 | 1/1/94-12/31/94 |
| US Healthcare | Brooklyn | 1/1/93-12/31/95 | 1/1/94-12/31/94 |
| US Healthcare | Manhattan | 1/1/93-12/31/95 | 1/1/94-12/31/94 |
| US Healthcare | Queens | 1/1/93-12/31/95 | 1/1/94-12/31/94 |
| Wellcare | Greene | 1/1/94-12/31/94 | 1/1/94-12/31/94 |
| Wellcare | Columbia | 1/1/94-12/31/94 | 1/1/94-12/31/94 |
| Wellcare | Albany | 1/1/94-6/30/95 | 1/1/94-12/31/94 |

| PLAN | COUNTY | CURRENT CONTRACT DATE | RATE DATE |
|---|---|---|---|
| Wellcare | Rensselaer | 1/1/94-12/31/94 | 1/1/94-12/31/94 |
| Wellcare | Rockland | 1/1/94-12/31/94 | |
| Wellcare | Sullivan | 2/1/94-6/30/95 | 7/1/93-6/30/94 |
| Westchester PHSP | Westchester | 1/1/94-12/31/94 | 1/1/94-12/31/94 |
| Westchester PHSP | Rockland | 6/1/93-5/31/94 | 1/1/94-12/31/94 |
| HCP | Erie | 4/1/93-3/31/94 | 4/1/94-3/31/95 |
| IHA | Erie | 4/1/93-3/31/94 | 4/1/94-3/31/95 |
| IHA | Niagara | 4/1/93-3/31/94 | 4/1/94-3/31/95 |
| LMC | Brooklyn | 4/1/92-3/31/95 | 4/1/94-3/31/95 |
| Rochester Gen. | Monroe | | 4/1/94-3/31/95 |
| CHP | Clinton | 1/1/94-7/31/94 | 6/1/93-5/31/94 |
| Aetna | Brooklyn Demo | 1/1/93-12/31/95 | 7/1/93-6/30/94 |
| Beth Abraham OnLOK | Bronx | | 7/1/93-6/30/94 |
| Blue Care Plus | Herkimer | 7/1/93-6/30/94 | 7/1/93-6/30/94 |
| Blue Care Plus | Madison | 7/1/93-6/30/94 | 7/1/93-6/30/94 |
| Blue Care Plus | Oneida | 7/1/93-6/30/94 | 7/1/93-6/30/94 |
| Choicecare | Suffolk | 7/1/93-6/30/94 | 7/1/93-6/30/94 |
| Choicecare | Nassau | 6/1/93-5/31/94 | 7/1/93-6/30/94 |
| CHSP | Brooklyn | 9/1/93-8/31/96 | 7/1/93-6/30/94 |
| Cigna | Brooklyn Demo | 7/1/93-12/31/95 | 7/1/93-6/30/94 |
| HIP | Suffolk | 7/1/93-6/30/94 | 7/1/93-6/30/94 |
| HIP | Nassau | 7/1/93-6/30/94 | 7/1/93-6/30/94 |
| HIP | Westchester | 7/1/93-6/30/94 | 7/1/93-6/30/94 |
| HIP | NYC | 7/1/92-6/30/95 | 7/1/93-6/30/94 |
| HIP | Westchester | 7/1/93-6/30/94 | 7/1/93-6/30/94 |

| PLAN | COUNTY | CURRENT CONTRACT DATE | RATE DATE |
|---|---|---|---|
| Managed Hlth. Inc. | Queens | 1/1/93-12/31/95 | 7/1/93-6/30/94 |
| MHP | Bronx | 7/1/92-6/30/95 | 7/1/93-6/30/94 |
| MHP | Manhattan | 7/1/92-6/30/95 | 7/1/93-6/30/94 |
| MHP | Brooklyn | 7/1/92-6/30/95 | 7/1/93-6/30/94 |
| MHP | Queens | 7/1/92-6/30/95 | 7/1/93-6/30/94 |
| Oxford | Nassau | | 7/1/93-6/30/94 |
| Oxford | Rockland | 3/1/94-12/31/95 | 7/1/93-6/30/94 |
| Oxford | Brooklyn Demo | 1/1/93-12/31/95 | 7/1/93-6/30/94 |
| Oxford | Bronx | 1/1/93-12/31/95 | 7/1/93-6/30/94 |
| Oxford | Manhattan | 1/1/93-12/31/95 | 7/1/93-6/30/94 |
| Oxford | Queens | 1/1/93-12/31/95 | 7/1/93-6/30/94 |
| Oxford | Westchester | | 7/1/93-6/30/94 |
| Oxford | Suffolk | | 7/1/93-6/30/94 |
| Travelers | Onondaga | 7/1/93-6/30/94 | 7/1/93-6/30/94 |
| Wellcare | Rockland | 1/1/94-12/31/94 | 7/1/93-6/30/94 |
| Wellcare | Dutchess | 7/1/93-6/30/94 | 7/1/93-6/30/94 |
| Wellcare | Orange | 7/1/93-6/30/94 | 7/1/93-6/30/94 |
| Wellcare | Ulster | 7/1/93-6/30/94 | 7/1/93-6/30/94 |
| Wellcare | Sullivan | 2/1/94-6/30/95 | 7/1/93-6/30/94 |
| CHP | Orange | 8/1/93-7/31/94 | 8/1/93-7/31/94 |
| CHP | Schoharie | 4/1/94-7/31/95 | 4/1/94-7/31/94 |
| CHP | Dutchess | 8/1/93-7/31/94 | 8/1/93-7/31/94 |
| CHP | Ulster | 8/1/93-7/31/94 | 8/1/93-7/31/94 |
| CHP | Warren | 8/1/93-7/31/94 | 8/1/93-7/31/94 |

| PLAN | COUNTY | CURRENT CONTRACT DATE | RATE DATE |
|---|---|---|---|
| CHP | Columbia | 8/1/93-7/31/94 | 8/1/93-7/31/94 |
| CHP | Otsego | 8/1/93-7/31/94 | 8/1/93-7/31/94 |
| CHP | Albany | 8/1/93-12/31/94 | 8/1/93-7/31/94 |
| CHP | Delaware | 8/1/93-7/31/94 | 8/1/93-7/31/94 |
| CHP | Clinton | 8/1/93-7/31/94 | 8/1/93-7/31/94 |
| CHP | Schenectady | 5/1/94-7/31/95 | 8/1/94-7/31/94 |
| CHP | Saratoga | 8/1/93-7/31/95 | 8/1/93-7/31/94 |
| CHP | Rensselaer | 8/1/93-7/31/94 | 8/1/93-7/31/94 |
| Syracuse PHSP | Onondaga | 8/1/93-7/31/94 | 8/1/93-7/31/94 |
| Better Health | Rensselaer | 5/1/94-8/31/96 | 9/1/93-8/31/94 |
| Better Health | Albany | 5/1/94-8/31/95 | 9/1/93-8/31/94 |
| Better Health | Niagara | 4/1/94-8/31/95 | 9/1/93-8/31/94 |
| Better Health | Erie | 5/1/94-4/30/95 | 9/1/93-8/31/94 |
| Community Blue | Erie | 9/1/93-8/31/94 | 9/1/93-8/31/94 |
| Manhattan PHSP | Manhattan | 9/1/92-8/31/95 | 9/1/93-8/31/94 |
| Prucare | Suffolk | | 9/1/93-8/31/94 |
| Prucare | Orange | 5/1/93-8/31/94 | 9/1/93-8/31/94 |
| Prucare | Nassau | | 9/1/93-8/31/94 |
| Prucare | Putnam | 9/1/93-8/31/94 | 9/1/93-8/31/94 |
| Prucare | Dutchess | 9/1/93-8/31/94 | 9/1/93-8/31/94 |
| Prucare | Ulster | 9/1/93-8/31/94 | 9/1/93-8/31/94 |
| CDPHP | Schoharie | Pending | |
| Choicecare | Queens | Pending | |
| Community Blue | Niagara | 11/1/93-8/31/94 | 9/1/93-8/31/94 |
| Community Blue | Chautauqua | 9/1/93-8/31/94 | 9/1/93-8/31/94 |

| PLAN | COUNTY | CURRENT CONTRACT DATE | RATE DATE |
|---|---|---|---|
| Genesis | Orange | | 3/1/94-2/28/95 |
| GHI | NYC | Pending | |
| IHA/HV | Rockland/Putnam | | 1/1/94-12/31/94 |
| IHA/WNY | Genesee | | 4/1/94-3/31/95 |
| IHA/WNY | Chautauqua | Pending | |
| MetLife | Dutchess, Ulster | Pending | |
| MetLife | Westchester/ Rockland | Pending | |
| MVP | Broome | | 1/1/94-12/31/94 |
| MVP | Orange | | 1/1/94-12/31/94 |
| Preferred Care | Suffolk | Pending | |
| Preferred Care | Genesee | Pending | |
| Sanus | Queens | 1/1/93-12/31/95 | 1/1/94-12/31/94 |
| St. Barnabas | Bronx | | 9/1/93-8/31/94 |
| Travelers | Oswego/Madison | 7/1/93-6/30/94 | 7/1/93-6/30/94 |
| IHA | Orange | 8/1/93-12/31/93 | 1/1/94-12/31/94 |

# PROTOCOL FOR LINKAGE BETWEEN MANAGED CARE PROVIDERS (MCP) AND SPECIAL CARE PROVIDERS OF CARVED OUT SERVICES (SCP)

In all situations where a managed care enrollee receives any of the special care services contained in Attachment I; and in the absence of a formal agreement between the MCP and SCP, the managed care provider and special care provider will communicate with each other in a timely fashion about the diagnosis and treatment of the enrollee. If formal agreements exist, they must be consistent with the Protocol. The special care provider will request the authorization of the MCP for any service which is covered in the MCP benefit package; and will refer to providers who belong to the MCP network. The MCP will establish reasonable procedures for both authorization and timely payment for such authorized covered services.

## I. Timely Communication

A. The MCP and SCP will each establish procedures for obtaining consent for the sharing and transfer of patient specific information. These procedures will be consistent with all relevant confidentiality statutes and regulations.

B. The MCP and SCP will each designate for each patient a primary contact clinician who will be responsible for direct and timely communication of clinical information about the individual, including diagnosis, treatment, physical and special care health status and/or changes in physical or special care health status. Such information shall include, but not be limited to, progress reports, treatment plans, medication protocols and changes in medication; and shall be initiated when the enrollee seeks special care services.

1. The SCP will notify the MCP contact clinician as soon as possible but no later than 24 hours of the initial presentation by the enrollee.

2. The MCP and SCP will exchange the information listed above on a periodic basis as often as needed by either the MCP or SCP, but which shall be no less than every 3 months.

C. The MCP and SCP each will designate and inform each other of primary contact individuals for the exchange of administrative information, if different than the primary contact clinician.

## II. Prior Authorization/Timely Payment

A. The MCP will establish reasonable procedures for the consideration of denial or approval of MCP covered services which are requested by the SCP.

1. The SCP will request and receive authorization for MCP covered services prior to initiating any referral for services. Such authorization requests will be made as soon as possible, but no later than 24 hours after determining the need for the services in question, except in medical or psychiatric, drug and alcohol emergency situations (see IV).

2. The MCP will render a determination regarding a request for authorization for covered services within a time frame that permits appropriate medical care, not to exceed one business day; or, for urgent care, 24 hours after the request or 24 hours after the receipt of appropriate medical documentation, if required.

B. For hospitalizations related to special care needs, the MCP is responsible for hospitalization as a covered benefit. However, the MCP and SCP will establish procedures for coordination of admissions, inpatient physician care, and discharge planning, within the following time frames:

1. The SCP will request and receive authorization for admissions requested by the SCP prior to initiating the admission. Such admission requests will be made as soon as possible, but no later than 24 hours after determination of the need for hospitalization.

2. The MCP will render a determination regarding a request for hospital admission within a time frame that permits appropriate medical care, not to exceed 24 hours after the request or 24 hours from the receipt of appropriate medical documentation, if required.

3. The MCP will provide the SCP with a copy of the discharge plan and follow-up treatment recommendations within 48 hours of the discharge.

4. The SCP will notify the MCP within 48 hours of the patient receiving such follow-up treatment.

C. The MCP will establish reasonable procedures for timely payment of authorized covered services, which are appropriately ordered by the SCP. The MCP will pay claims for authorized covered services in accordance with the terms of contracts between the MCP and local districts, and between the MCP and providers of covered services; and in accordance with applicable Utilization Review (UR) procedures.

III. MCP Network

A. The SCP will utilize the MCP's network of providers for services covered by the MCP, (e.g.: hospitals, pharmacy, etc.).

B. The MCP will furnish the SCP with the necessary information regarding the MCP networks. The MCP and SCP will establish procedures to periodically up-date MCP provider network information.

IV. Emergency Care

A. The MCP and SCP each will establish procedures for the continuity and coordination of care for managed care enrollees who need or are receiving carved-out special care services when such individuals seek emergency care.

1. The SCP, if notified by the ER or enrollee, will notify the MCP as soon as possible, but no later than 48 hours after an enrollee seeks emergency care related to his/her special care needs.

2. The SCP, if notified by the ER that emergency care will result in an inpatient admission, will notify the MCP as soon as possible, but no later than 48 hours after such emergency care results in an inpatient admission.

3. The MCP, if notified by the ER or enrollee, will notify the SCP as soon as possible, but no later than 48 hours after an enrollee seeks emergency care related to his/her special care needs.

B. The definitions of general health, alcohol/substance abuse, and psychiatric emergencies are included as Attachment II.

V. Dispute Resolution

A. The MCP and SCP each will establish a mutually agreeable internal appeals mechanism for the review and resolution of any disputes regarding the request, authorization, and/or provision of services covered by the MCP or other matters of mutual concern. At a minimum, these mechanisms should:

(1) contain reasonable timeframes for resolution; and
(2) base grievance review on mutually acceptable clinical protocols for delivery of the services in question.

B. To the extent possible, existing dispute resolution processes should be used, where appropriate.

PROTOCOL AGREEMENT STATEMENT

It is understood that (Name of provider) a, (MCP,SCP) having its principal office at:

(Provider address)

hereby agrees to adhere to the Protocol set forth above in relation to the provision of services to individuals with special needs who are enrolled in managed care.

BY: _____

Name (printed) _____

Title _____

Date _____

OMH

Intensive psychiatric rehabilitative treatment (IPR) services

A time limited 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 rehabilitative technologies to overcome functional disabilities. IPR services are certified by OMH in accordance with the requirements of 14 NYCRR Part 587.12.

Day Treatment Services

A combination of diagnostic, treatment and rehabilitative procedures which, through supervised and planned activities and extensive client-staff interaction, provides the services of the clinic treatment program, as well as social training, task and skill training and socialization activities. Service is expected to be of six months duration. Day Treatment services are certified by OMH under the requirements of 14 NYCRR, Part 585.11.

Continuing Day Treatment Services

Provides treatment designed to maintain or enhance current levels of functioning and skills, maintain community living, and develop self-awareness and self-esteem. Includes: assessment and treatment planning; discharge planning; medication therapy; medication education; case management; health screening and referral; rehabilitative readiness development; psychiatric rehabilitative readiness determination and referral; and symptom management. CDT Services are ceritifed by OMH under the requirements of 14 NYCRR, Part 587.10.

Intensive Case Management (ICM)

The target population consists of individuals who are seriously and chronically mentally ill, require intensive, personal and proactive intervention to help them obtain those services which will permit functioning in the community and either have symptomology which is difficult to treat in the existing mental health care system or are unwilling or unable to adapt to the existing mental health care system.

Partial Hospitalization Services

Provide active treatment designed to stabilize and ameliorate acute systems, serve as an alternative to inpatient hospitalization, or reduce the length of a hospital stay within a medically supervised program by providing the following: assessment and treatment planning; health screening and referral; symptom management; medication therapy; medication education; verbal therapy; case management; psychiatric

rehabilitative readiness determination and referral; and crisis intervention. Partial Hospitalization services are certified by OMH under the requirements of 14 NYCRR, Part 587.22.

Rehabilitation Services provided to residents of OMH licensed CR's and family based treatment programs

OMH licensed CR's:

Rehabilitative services in community residences are interventions, therapies and activities which are medically therapeutic and remedial in nature, and are medically necessary for the maximum reduction of functional and adaptive behavior deficits associated with the person's mental illness.

Family-based treatment:

Rehabilitative services in family-based treatment programs are intended to provide treatment to seriously emotionally disturbed children and youth to promote their successful functioning and integration into the natural family, community, school or independent living situations. Such services are provided in consideration of a child's developmental stage. Those children determined eligible for admission are placed in surrogate family homes for care and treatment.

Rehabilitation services for CR and FBT programs are certified by OMH under the requirements of 14 NYCRR, Part 586.3.

Services for children with serious emotional disturbance (SED)

These are services provided to children and adolescents with serious emotional disturbance by OMH clinics. Children meeting the SED definition must have certain DSM-III diagnoses as well as meeting other at risk or functional impairment criteria. OMH will develop regulations which define and establish new categories for certification of these services. In the interim, OMH will designate certain clinic providers who will be able to provide and bill for services to these children.

OMRDD

Care at Home

"Care at Home" waivers serve children who would not be eligible for Medicaid due to parents' income and resources and who are physically disabled according to SSI criteria and who are determined capable of being cared for at home if provided additional waivered services. These services are authorized pursuant to a 1915 (c) waiver from the DHHS.

Home and Community Based Services

The Home and Community Based Waiver Program serves developmentally disabled persons who would otherwise be admitted to an ICF/MR if waivered services were not provided. The services provided include case management, respite, medical social counseling, nutrition counseling, respiratory therapy, and home adaptations. These services are authorized pursuant to a 1915 (c) waiver from the DHHS.

Day Treatment

A planned combination of diagnostic, treatment and rehabilitation services provided to developmentally disabled individuals in need of a broad range of services. The services provided as identified in the comprehensive assessment may include nutrition, recreation self-care, independent living, therapies, nursing, and transportation services. Day Treatment services are certified by OMRDD under the requirements of 14 NYCRR, Part 690.

Habilitation Services provided by Article 16 - or Article 28 facilities

These services to persons with developmental disabilities include medical or remedial services recommended by a physician or other licensed practitioner of the healing arts for a maximum reduction of the effects of physical or mental disability and restoration of the person to his or her best possible functional level. The services may include nursing, nutrition, PT, speech therapy, audiology, psychology, social work, and rehabilitation counseling. It also includes the fitting, training, and modification of assistive devices by licensed practitioners or trained others under their direct supervision. Such services are designed to ameliorate or limit the disabling condition and to allow the person to remain in, or move to, the least restrictive residential and/or day setting. Habilitation services are certified by OMRDD under the requirements of 14 NYCRR, Part 679.

Comprehensive Medicaid Case Management Services (OMRDD)

The target population consists of individuals who are developmentally disabled, in need of ongoing and comprehensive rather than incidental case management and reside in OMRDD Certified Family Care Homes, Community Residences, live independently or with family or reside in residential facilities certified by a state agency other than OMRDD and are referred by the residential facility, or its supervising or certifying agency. CMCM services are authorized under the requirements of 18 NYCRR, Part 505.16.

OASAS

Methadone Maintenance Treatment Program

Consists of drug detoxification, drug dependency counseling, and rehabilitation services which include chemical management of the patient with methadone. Facilities that provide methadone maintenance treatment do so as their principal mission and are certified by the Office of Alcohol and Substance Abuse Services. MMTP services are certified by OASAS under the requirements of 14 NYCRR, Part 1040.1.

Substance Abuse Services Provided by 1035 Facilities

These programs provide medically supervised ambulatory substance abuse treatment that focuses on medical oversight of clients with health conditions in addition to their substance abuse. Individual and group counseling for the primary client and his/her significant others, psychological evaluations, and educational, vocational, and social services are made available to each client to help the client address and resolve the substance abuse problem. These services are certified by OASAS under the requirements of 14 NYCRR, Part 1035.

Outpatient Alcoholism Rehabilitation

Outpatient alcoholism rehabilitation programs provide intensive full or half-day services to meet the needs of specific target population. When appropriate, they may be operated independently of outpatient clinics, if they remain affiliated with an accessible clinic program. Most outpatient rehabilitation programs will have a separate, identifiable and specially designed environment and specific target population of chronic alcoholic persons who need a range of services which are different from those typically provided in an alcoholism outpatient clinic. Outpatient Alcoholism Rehabilitation services are certified by OASAS under the requirements of 14 NYCRR, Part 372.3.

*Therapeutic Communities (Residential drug-free treatment services)

Therapeutic Communities are substance abuse programs in which drug free substance abuse treatment and living accommodations are provided to substance abusers and substance dependent persons. Persons residing in therapeutic communities receive intensive counseling and comprehensive rehabilitative services such as vocational, educational, and legal. Residents usually receive their health care services from affiliated providers. TC's are certified by OASAS under the requirements of 14 NYCRR, Part 1030.1.

*Community Residence Alcoholism Treatment

Community Residence means a residential facility with cooperative relations to a comprehensive delivery system for persons suffering from alcoholism. CRs include halfway houses, recovery homes and supportive living facilities; and residential chemical dependency programs for

youth (Part 382). Medicaid recipients residing in OASAS certified community residences receiving alcoholism treatment services would be eligible to join managed care programs for health care only when such program become available. CR Alcoholism Treatment services are certified by OASAS under the requirements of 14 NYCRR, Part 375.3.

* Individuals residing in these facilities are ineligible for enrollment in a managed care plan.

General Emergency

Emergency medical care is covered by the managed care provider regardless of the site of such care. An emergency is defined in the Medicaid Model Contract for Fully Capitated Providers as a sudden onset of a medical condition manifesting itself by acute symptoms or sufficient severity that the absence of immediate medical treatment could reasonably result in serious impairment of bodily functions, serious dysfunction of a bodily organ or body part or would otherwise place the enrollee's health in serious jeopardy.

In an emergency, enrollees are directed to seek care immediately and notify the managed care provider afterwards, usually within 48 hours, unless the enrollee's medical condition prevents it. If an emergency admission occurs at a non-network hospital, the managed care provider may transfer the enrollee to a network hospital once the attending physician at the hospital determines that the patient is medically stable for transfer.

Psychiatric Emergency

An individual shall be deemed in need of an emergency admission if that person meets the criteria of having a diagnosable mental illness or significant symptoms of mental illness and which are likely to result in serious harm to self or others. This includes alcohol and/or other psychoactiove substance induced reactions which subject the individual to a temporary psychotic state.

Likelihood of serious harm is defined as follows:

a. Substantial risk of physical harm to self as manifested by threats of, or attempts at suicide, or serious bodily harm or other conduct demonstrating dangerousness to self, such as serious impaired judgement due to severe intoxification or withdrawl delirium states.

b. A substantial risk of physical harm to another person as manifested by homicidal or other violent behavior by which others are placed in reasonable fear of serious physical harm.

Drug and Alcohol Emergency

An intoxicated person may request emergency treatment from an alcoholism facility or any other facility authorized by the Commissioner of the Office of Alcoholism and Substance Abuse Services and, if found suitable by authorized personnel, be given emergency care.

An intoxicated person who is brought to such a facility despite their objection, shall be examined as soon as possible by an examining

physician. If the physician determines that the person is incapacitated by alcohol to the degree that they may endanger themselves, or other person or property, they may be retained for emergency treatment. In no event shall such person be retained against their objection beyond the time that they are no longer incapacitated by alcohol or a period longer than 24 hours.

Alcohol Crisis Centers provide short term non-acute care for uncomplicated acute detoxification or withdrawal states. Alcohol Primary Care Programs may provide medically supervised alcohol detoxification in a non-hospital setting. These services require by regulation that each individual's discharge plan include referral to the appropriate level of ongoing alcoholism treatment immediately upon discharge.

If identified as an enrollee in a managed care program, a contact shall be made to the managed care provider upon admission. The managed care provider shall, in consultation with the service provider, then advise the managed care provider of the disposition to emergency care.