METROPLUS HEALTH PLAN

PROVIDER TRAINING GUIDE FOR VFCA

MetroPlusHealth

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METROPLUS OVERVIEW

MetroPlus is a Prepaid Health Services Plan (PHSP) licensed to operate in:

- Manhattan
- Brooklyn
- Queens
- Bronx
- Staten Island (Currently for Medicaid, Child Health Plus, HARP, Marketplace, and Essential Plan only)

MetroPlus, which began operations in 1985, is a wholly owned subsidiary of NYC Health + Hospitals.

METROPLUS PRODUCT LINES

- Medicaid Managed Care (MMC)
- Child Health Plus (CHP)
- Qualified Health Plan (MarketPlace Plans)
- Partnership in Care (SNP)
- Essential Plan (EP)
- MetroPlus Medicare Advantage Plan (HMO SNP)
- MetroPlus Medicare Platinum Plan (HMO)
- UltraCare (Medicaid Advantage Care (MAP))
- MetroPlus Gold
- MetroPlus Managed Long Term Care (MLTC)
- MetroPlus Enhanced

MEMBER ELIGIBILITY VERIFICATION

- ❑ Members' coverage and PCP must be verified before every encounter.
- ❑ Step 1: Ask to see their MetroPlus Member ID Card and a Photo ID
- ❑ Step 2: Check member's eligibility using one of these methods:
  - MetroPlus Provider Portal:

    http://providers.metroplus.org
  - EMEVS web site: www.emedny.org for Medicaid, Medicaid HIV SNP and MetroPlus Medicaid Advantage.
  - EMEVS verification line:
    - Call 800-997-1111
  - Enter the MetroPlus Provider Number 01529762 and the Plan Code 092
  - MetroPlus Customer Services: 800-303-9626

OVERVIEW: FOSTER CARE TRANSITION TO MMC

- Part of the Medicaid Redesign Children's System Transformation
- Voluntary Foster Care Agencies (VFCA) will be licensed under NYS Public Health Law Article 29-I to provide health related services
- 29-I Health Facility services will be included in MMC Plan benefit package effective July 1, 2021
- Children in the care of VFCAs will be enrolled in managed care beginning July 1, 2021

VFCA CORE PRINCIPLES UNDER CHILDREN'S MEDICAID REDESIGN AND TRANSITION TO MANAGE CARE

- ❑ Enhancing capacity to care for children placed with VFCAs and higher risk populations through both care management and coordination of mandated services
  - Services may be provided by a variety of staff who meet state licensing requirements in accordance with applicable state law
  - No loss of access to Medicaid services for children in foster care and families
- ❑ Article 29-I Licensure and standardized guidelines to deliver services under managed care framework
- ❑ MetroPlus will pay the Per diem rate for "Core Limited Health-Related Services" (defined by regulation)
- ❑ MCO/VFCA collaboration to support transition to new models/expectations

FOSTER CARE PROVIDERS

- Agencies designated for "Foster Care" ONLY can only provide CFTSS services to children who are in or discharged from foster care who meet medical necessity criteria, regardless of their diagnoses.
- Children in or discharged from foster care are not restricted to the foster care only agency sites. Children discharged from foster care can continue to be served by a foster care only agency to support continuity of care.

AUTHORIZATION/NOTIFICATION REQUIREMENTS

You must call MetroPlus Customer Services at **800-303-9626** to obtain prior authorization and/or verification of benefits for the following services:

- Services provided by a Non-Participating Provider
- Behavioral Health and Substance Abuse Services (Benefits managed by Beacon Health Options)
  - Authorization required for inpatient services
  - Authorization for outpatient (See Beacon Provider Manual for details)
- Inpatient Admissions, Home Health Care, Skilled Nursing Facility Care, Durable Medical Equipment, Personal Care, Erectile Dysfunction Treatments, Potentially Cosmetic Procedures
- Physical Therapy, Occupational Therapy and Speech Therapy
  - MetroPlus members enrolled in **Medicare Advantage, Child Health Plus, MetroPlus Gold** and “exempt” **Medicaid** members who are children 0 – 20 years of age and/or members with developmental disabilities will not be subject to the mandated benefit limit of twenty (20) visits per specialty type per calendar year but will still require authorization for services after visit number twenty.
  - For all other non-exempt **Medicaid** members, there is a benefit limit of 20 visits per specialty type per calendar year. There is no means or opportunity to request an approval or an authorization that will allow for additional visits to be approved.

AUTHORIZATION/NOTIFICATION REQUIREMENTS

- MetroPlus Health Plan does **not** require authorization or notification for any of the six Children and Family Treatment Support Services (CFTSS)
- For Medical Authorization please refer to our authorization grid on our website **https://www.metroplus.org/provider/tools**
- No utilization management will be conducted for:
  - CLHRS provided by a 29-I Health Facility with which an enrollee is placed; or
  - On any required assessment for a child/youth in foster care; mandated by OCFS or the LDSS; or ordered by a court.
- For children in foster care transitioning to managed care on **7/1/2021**, MHP will facilitate continued access to requested services without interruption and without conducting utilization review for LTSS, HCBS, or OLHRS **at least 180 days** from the effective date of enrollment.

METROPLUS WEBSITE & PROVIDER PORTAL

- To register and access information 24/7 VISIT www.metroplus.org
  - Provider Manual, Provider Newsletters
  - Benefits
  - Provider Search, Provider Directory (PDF)
- MetroPlus Provider Portal is a secure, HIPPA-compliant website that enables participating network providers to conduct online claims and authorization transactions accurately and efficiently, while providing them the opportunity to spend more time with who matters most-their patients.
- **Once you register, you can access the Provider Portal to:**
  - Verify member eligibility, coverages, and benefit documents
  - Submit batch claims, re-credentialing applications ,provider updates, and access Provider Orientation
  - View and submit authorization and referral requests
  - Print forms and authorization letters
- MetroPlus Provider Portal home page

http://providers.metroplus.org

METROPLUS HEALTH PLAN VENDOR INFORMATION

- **Beacon Health Options** is contracted with MetroPlus Health Plan to provide Behavioral Health and Substance Abuse Benefit Management Services. Contact Beacon for authorization at **1-855-371-9228**.
- **Integra Partners** is contracted with MetroPlus Health Plan to provide Durable Medical Equipment (DME) benefit management services. Contact Integra Partners for prior authorizations at **1-866-679-1647** or via fax at **1-212-908-5185**.
- **HealthPlex** is contracted with MetroPlus Health Plan to provide Dental Benefit Management services, including utilization management for dental. Contact HealthPlex at **1-888-468-2183**.

REVIEW OF THE BASICS: WHAT IS ARTICLE 29-I?

Article 29-I licensure authorizes VFCAs to provide the following:

- **Core Limited Health-Related Services (CLHRS)**
  - Nursing, Skill Building, and Medicaid Treatment Planning and Discharge Planning, Clinical Consultation and Supervision, Managed Care Liaison/Administrator

- **Other Limited Health-Related Services (OLHRS)**
  - Medicaid State Plan services (CFTSS)
  - Medicaid Home and Community Based Services (HCBS) for Children
  - Other Health-Related Services (such as psychiatric, psychological, etc.)

Voluntary Foster Care Agencies (VFCAs) must be licensed for the provision of Core and Other Limited Health-Related services and bill Medicaid Managed Care Plans to comply with the Corporate Practice of Medicine Standards

CORE LIMITED HEALTH RELATED SERVICES PER DIEM RATE REIMBURSEMET LEVELS

LEVEL	DESCRIPTION	FACILITY TYPE
LEVEL 1	GENERAL TREATMENT	• FOSTER BOARDING HOME
LEVEL 2	SPECIALIZED TREATMENT	• THERAPEUTIC BOARDING HOME (TBH)/AIDS • MEDICALLY FRAGILE (FORMALLY BORDER BABIES) • SPECIAL NEEDS
LEVEL 3	CONGREGATE CARE	• MATERNITY • GROUP HOME (GH) • AGENCY OPERATED BOARDING HOME (ABH) • SUPERVISED INDEPENDENT LIVING PROGRAM (SILP)
LEVEL 4	SPECIALIZED CONGREGATED CARE	• GROUP RESIDENCE (GR) • DIAGNOSTIC • INSTITUTIONAL • HARD TO PLACE/OTHER CONGREGATE • RAISE THE AGE

OPTIONAL Article 29-I SERVICES

- **Referred to as Other Limited Health Related Services (OLHRS)** and reimbursed according to a 29-I OLHRS Fee Schedule

- **Physical and Behavioral Health** screening, diagnosis and treatment services**,** including but not limited to:
  - On-going treatment of chronic conditions as specified in treatment plans
  - Diagnosis and treatment related to episodic care for minor ailments, illness or injuries, including sick visits
  - Psychiatric consultation, assessment and treatment
  - Psychotropic medication treatment
  - Developmental screening, testing and treatment
  - Psychological screening, testing and treatment
  - Smoking cessation treatment
  - Alcohol and/or drug screening and intervention
  - Laboratory Services
  - Children and Family Treatment and Support Services
  - Children's Home and Community Based Services

POPULATIONS SERVED BY ARTICLE 29-I FACILITIES

- ❑ Children/youth placed in foster care;
- ❑ Babies residing with their parent who are placed in a 29-I Health Facility and in foster care (8D Babies);
- ❑ Children/youth placed in a 29-I Health Facility by Committee on Special Education (CSE);
- ❑ Pre-dispositional placed youth; and
- ❑ Children/youth and adults who are discharged from a 29-I Health Facility (with limitations, as defined by the VFCA Policy Manual)

ARTICLE 29-I SERVICES DO NOT INCLUDE

- ❑ Surgical services
- ❑ Dental services
- ❑ Orthodontic care
- ❑ General hospital services including emergency care
- ❑ Birth center services
- ❑ Emergency intervention for major trauma
- ❑ Treatment of life-threatening or potentially disabling conditions
- ❑ Non-Routine Transportation

FUNDAMENTAL REQUIREMENTS FOR 29-I HEALTH FACILITY SERVICES

- ❑ Voluntary Foster Care Agencies (VFCAs) must obtain and maintain an Article 29-I Health Facility license from the Department of Health to provide Health Related Services
- ❑ The child's/youth's health/behavioral health record, treatment plan, service plan and/or plan of care must reflect that the services provided were medically necessary and appropriate and were rendered by qualified practitioners within their scope of practice (including supervision requirements), as defined in applicable State Law
- ❑ 29-I Health Facilities who wish to provide CFTSS and HCBS are required to receive the appropriate designation(s) from the State.
- ❑ **29-I Health Facilities providing laboratory services must have a valid Clinical Laboratory Improvement Amendments (CLIA) certification and only provide laboratory services outlined in their CLIA certification.**

WHO CAN RECEIVE THESE SERVICES?

- Any **Medicaid** eligible child who is **currently placed** with a VFCA can receive Core Limited Health-Related Services, Other Limited Health-Related Services, CFTSS, and HCBS from that VFCA if:

  - The VFCA has an Article 29-I license to provide Core Limited Health-Related Services, and;
  - It is designated to provide CFTSS or HCBS services, and;
  - The child is Medicaid eligible AND the child meets medical necessity for CFTSS or meets HCBS criteria and;
  - Contracted and credentialed with Managed Care to deliver Core Limited Health-Related Services and Other Limited Health-Related Services for children in MCOs.
  - Notification of placement via Transmittal Form or other approved method is provided to MetroPlus Children's Special Services department.
    - Additional details and contact information is on slide 22

WHO CAN RECEIVE THESE SERVICES (CONTINUED)?

Any child who is **currently not placed** with your VFCA can receive Other Limited Health-Related Services, inclusive of CFTSS and HCBS, from your VFCA under the following circumstances:

- **Post** final discharge from foster care: CFTSS and/or HCBS can be provided to support continuity of care with no timeline for children/you up to age 21.
- **Post** final discharge from foster care: Other-Limited Health-Related Services specific to physician, psychiatrist, psychologist etc. can be provided for one year.
- A VFCA provider can provide CFTSS and Other Limited Health-Related Services to any child placed in another VFCA that is not already providing these services at the time or children in the direct placement of a Local Department of Social Services.

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NOTIFICATION OF FOSTER CARE PLACEMENT

- VFCAs **must** notify managed care using the **Transmittal Form** about children placed in foster **when:**
  - They are newly placed in foster care,
  - Their level of placement has changed (to a different level or to a different address within the same level),
  - They are discharged from foster care.

- The **Foster Care Liaison** is the dedicated staff person in the Children's Special Services (CSS) department who will receive this notification, coordinate the issuance of an updated MetroPlus eligibility letter and card to the VFCA, and assist with coordinating care.

- Transmittal Forms may be submitted via:
  - CSS Email: childrensspecialservice@metroplus.org
  - CSS Fax: 212-908-3018
  - Provider Portal

Contacting the Foster Care Liaison (FCL)

The Children's Special Services Department has assigned a contact and created a direct line for VFCAs, ACS, and LDSS to communicate with MHP:

MetroPlus Foster Care Liaison: Olanike (Nikki) Oyeyemi
Direct line: 212-908-4000
Cell phone: 646-599-5965
oyeyeo@metroplus.org

- Contact the MHP Foster Care Liaison to:
  - Coordinate care for members
  - Refer members to care management
  - Collaborate on discharge planning from an inpatient admission
  - Collaborate on discharge planning from foster care

CLAIM SUBMISSION

Claims must be submitted detailing all services rendered for all capitated and fee-for-service encounters within 90 days of the date of service or discharge. Please allow **30 days from claim submission date** to receive payment for **Medicare claims**, **45 days** for all **other claims**.

- Claims for all members can be submitted electronically using **Emdeon Payer ID# 13265.**
- Paper claims must be submitted on **HCFA 1500 or UB-04 forms.**
- A guide for completing a **UB-04** can be found at https://www.metroplus.org/provider/tools
- **29-I billing guidance can be located at** https://www.metroplus.org/provider/tools

Send paper claims for Medicaid, Child Health Plus, Essential Plan and MetroPlus Gold to:

MetroPlus Health Plan
P.O. Box 830480
Birmingham, AL 35283-0480

PAPER CLAIM SUBMISSION (UB04)

1	Yes	Provider Name, Address, Telephone #
2	Yes	Service Facility if different from box 1
3	No	Provider's Member Account Number
4	Yes	Type of Bill (See Table 7-3 for 3-digit codes)
5	Yes	Federal Tax ID Number
6	Yes	Statement Covers Period (include date of discharge)
7	Yes	Covered Days (do not include date of discharge)
8	Yes	Member Name
9	Yes	Member Address
10	Yes	Member Birth Date
11	Yes	Member Sex
12	No	Admission Date
13	No	Admission Hour
14	No	Admission Type
15	No	Admission Source
16	No	Discharge Hour
17	No	Discharge Status (See Table 7-2: Discharge Status Codes)
18 -28	No	Condition Codes
29	No	ACDT States
30	No	Unassigned
31-34	No	Occurrence Code and Date
35-36	No	Occurrence Span
37	No	Not used by Beacon.
38	No	Untitled
39-41	Yes	Value CD/AMT, Include "24" followed immediately by 4 digit rate code based on facility type.
42	Yes	Revenue Code (if applicable)
43	Yes	Revenue Description
44	Yes	Procedure Code (CPT) (Modifier may be placed here beside the HCPCS code. See Table 7-4 for acceptable modifiers.)
45	Yes	Service Date
46	Yes	Units of Service
47	No	Total Charges
48	No	Non-Covered Charges
49	Yes	Modifier (if applicable; see Table 7-4 for acceptable modifiers)

Highlighted are the required fields. **In addition, diagnosis code is also a required field.**

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PAPER CLAIM SUBMISSION (UB04)

50	No	Payer Name
51	No	Beacon Provider Id Number
52	No	Release of Information Authorization Indicator
53	No	Assignment of Benefits Authorization Indicator
54	No	Prior Payments (if applicable)
55	No	Estimated Amount Due
56	Yes	Facility NPI
57	Yes	Other ID (Rendering Taxonomy and/or Medicaid ID)
58	Yes	Insured's Name
59	No	Member's Relationship to Insured
60	Yes	Member's Identification Number
61	No	Group Name
62	No	Insurance Group Number
63	No	Prior Authorization Number (if applicable)
64	Yes	RecID Number for Resubmitting a Claim (if applicable)
65	No	Employer Name
66	No	Employer Location
67	No	Principal Diagnosis Code
68	No	A-Q Other Diagnosis
69	No	Admit Diagnosis. Not needed for outpatient claims
70	No	Patient Reason Diagnosis
71	No	PPS Code
72	No	ECI
73	No	Unassigned
74	No	Principal Procedure
75	No	Unassigned
76	Yes	Attending Physician NPI/TPI, First and Last Name and NPI
77	No	Operating Physician NPI/TPI
78-79	No	Other NPI
80	No	Remarks
81	Yes	Code-Code (Billing Taxonomy)

Highlighted are the required fields. . **In addition, diagnosis code is also a required field.**

GUIDANCE ON CLAIMS SUBMISSION

- Bill MHP following guidance posted by the state in the Children's Health and Behavioral Health Billing and Coding Manual. **A valid diagnosis code is required.**
- Make sure to use a valid combination of procedure codes, modifiers and rate codes. Claims should be submitted following State guidance as outlined in the State Taxonomy Grid.
- MHP offers claims testing for new providers. We encourage providers to take advantage of this. For more details, please contact our Provider Relations Department at networkrelations@metroplus.org

GUIDANCE ON CLAIMS SUBMISSION

- ❑ Verify if services are covered by MHP or carved out to Medicaid Fee for Service.
- ❑ Make sure a member is eligible for the services on the date's services are rendered.
- ❑ Ensure to submit claims within the timely filing limit.
- ❑ Submit “primary” and “add-on” codes on the same claim form.
- ❑ Use UB04- Inpatient Institutional form.

CONTACT INFORMATION

DEPARTMENT	Contact Information
Customer Service	MetroPlus Customer Services 800-303-9626
Claims Department	Cristina Gonzalez 212-908-3132
Utilization Management	Rosemary Salopek 212-908-3744
Foster Care Liaison	Olanike Oyeyemi 212-908-4000
Member Eligibility	MetroPlus Provider Portal: **http://providers.metroplus.org** EMEVS web site: **www.emedny.org** for Medicaid, Medicaid HIV SNP and MetroPlus and Medicaid Advantage.
Provider Relations	networkrelations@metroplus.org

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Q/A

- Open Discussion

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