Appendix 4A

New York Medicaid Advantage Plus (MAP) Plans with Behavioral Health Carve-in Services

Introduction[1]

Effective January 1, 2023, New York State is carving additional Behavioral Health (BH) services in to the Medicaid Advantage Plus (MAP) benefit package. Beacon Health Options Inc. (Beacon) will administer these BH benefits for members of certain NY MAP plans. The MAP product line is an integrated managed care plan that combines Medicaid—including Long-Term Services and Supports (LTSS)—and Medicare Advantage Dual Special Needs Plan coverage offered through the same health care organization. Under the oversight of New York's Department of Health (DOH), Office of Mental Health (OMH) and Office of Addiction Services and Supports (OASAS) and the Centers for Medicare and Medicaid Services (CMS), the MAP plans integrate services for Medicaid and Medicare dually-eligible individuals to streamline care and to better treat individuals' needs holistically. **One aspect of this integration is to carve in additional Medicaid behavioral health (BH) services into the Medicaid Advantage Plus (MAP) product line benefit package, effective January 1, 2023**.

Utilization management and authorization requirements for Medicaid mental health and addiction services included in the MAP benefit package will be the same as the requirements in Medicaid Health and Recovery Plans (HARPs) and the Mainstream Managed Care benefits. Medicare-covered services will follow the DSNP's benefit package rules.

A primary goal of integrated care is to remove barriers Duals often face with fragmented health coverage and lack of coordination. Integrated care allows members to receive both Medicare and Medicaid services through the same health plan, improving outcomes, enhancing member satisfaction and reducing costs. As a health care provider you may see an increase in the ability to provide continuous care for members newly becoming dual (see *Continuity of Care* below), improved care coordination between Medicare and Medicaid benefits, and streamlined administrative procedures with Managed Care Organizations (MCOs), including simplified billing.

[1] Information contained in this Appendix reflects the guidance issued by DOH as of 07/1/2022

Definitions

TERM	DEFINITION
Aligned	An aligned member, or a member in an aligned plan, refers to a member enrolled in a Medicaid managed care plan who is also enrolled in the organization's Medicare DSNP designated to operate in an integrated manner with the Medicaid managed care plan
Dually eligible individual or dual	Person eligible for both Medicare and Medicaid
Long-Term Services and Supports (LTSS)	LTSS means health care and supportive services provided to individuals of all ages with functional limitations or chronic illnesses who require assistance with routine daily activities such as bathing, dressing, preparing meals, and administering medications. LTSS is comprised of community-based services such as home health services, private duty nursing, consumer directed personal assistance services, adult day health care program, personal care services, and institutional services including long term placement in residential health care facilities
Dual-Eligible Special Needs Plan (D-SNP)	Dual Eligible Special Needs Plans (D-SNPs) are Medicare Advantage (MA) health plans which provide specialized care and wrap-around services for dual eligible beneficiaries (eligible for both Medicare and Medicaid)
Medicaid Advantage Plus (MAP)	Medicaid Advantage Plus (MAP) plans combine a Medicare Dual Eligible Special Needs Plan (D-SNP) with a Medicaid Managed Long-Term Care (MLTC) Plan from the same managed care organization to administer Medicare and Medicaid benefits including Medicaid Long-Term Services and Supports (LTSS)
Default Enrollment	Default Enrollment is a process to allow eligible insurers to move/enroll newly Medicare-eligible members into their MAP plan's affiliated Medicare Dual Eligible Special Needs Plan (D-SNP) at the time the member becomes dual-eligible for Medicare
HARP	Health and Recovery Plan or HARP is a specialized comprehensive Medicaid managed care plan offering integrated physical health, mental health, and substance abuse services for adults with significant behavioral health needs
Integrated Care	Integrated care occurs when a dual is enrolled in both a Medicaid managed care plan and a Medicare D-SNP, where both MCOs are operated by the same organization, and the MCOs work together as to appear and function as one MCO for the benefit of the member

Medicaid Advantage Plus (MAP)

MAP plans are offered in certain New York State counties and provide managed care to individuals who are eligible for (and enrolled in) Medicare and Medicaid (dually eligible) and *in need of certain amount of long-term care*.

Eligibility Criteria

To enroll in the MAP plan, individuals must be:

- 18 years or older
- Have full Medicaid and be eligible for Medicare Parts A and B
- Must need at least 120-days or more of long term care services and supports

The MAP plan allows the dual eligible person to remain in the community in their own home while receiving Medicaid, including LTSS, and Medicare services.

Covered Services

The Medicaid portion of the plan covers the following services only:

1. **OMH Government Rate Services**
   - Assertive Community Treatment (ACT)
   - Continuing Day Treatment (CDT)
   - Comprehensive Psychiatric Emergency Program (CPEP), including Extended Observation Bed (EOB)
   - Partial Hospitalization (PH) [Note: In addition to the OMH PH services, Medicare Partial Hospitalization Program (PHP) services are covered by the DSNP
   - Personalized Recovery Oriented Services (PROS) [Note: The DSNP may cover the clinic component.]

2. **OMH/OASAS Government Rate Services**
   - Community Oriented Recovery and Empowerment (CORE) Services
     - Psychosocial Rehabilitation (PSR)
     - Community Psychiatric Support and Treatment (CPST)
     - Family Support and Training (FST)
     - Empowerment Services – Peer Supports (Peer Supports)

3. **OASAS 1115 Waiver Demonstration Programs**
   - SUD Residential Treatment – Per Diem (Stabilization and Rehabilitation – and, upon CMS approval, Reintegration)

The following treatment services are <u>covered by Medicare and Medicaid</u>:

- Inpatient Hospital Care Including Substance Abuse and Rehabilitation Services
- Inpatient Mental Health
- Outpatient Mental Health and Rehabilitative Services
- Outpatient Chemical Dependence/Substance Abuse and Addiction Rehab
- Opioid Treatment Program (OTP)

Reimbursement Requirements

Beginning January 1, 2023, Beacon/MAP Plans will pay the "higher of" what Medicare or Medicaid would pay for BH ambulatory services that are reimbursable under both Medicare and Medicaid. With the principle of Medicaid being the payer of last resort, Medicaid is responsible for the remaining balance after the Medicare payment, up to the Medicaid rate if the Medicaid rate for the service is higher than Medicare. Medicaid reimburses 100 percent of the patient cost-sharing responsibility if the Medicare rate is higher than the Medicaid rate. The "higher of" requirement applies to the following services:

- Mental Health Outpatient Treatment and Rehabilitative Services
- Personalized Recovery Oriented Services (PROS) (Clinic component)
- Outpatient Medically Supervised Stabilization and Withdrawal (Detox)
- Outpatient Chemical Dependence (CD) Clinic (aka Outpatient Addiction Rehab)
- Outpatient CD Rehabilitation (aka Outpatient Addiction Day Rehab)
- Opioid Treatment Program (OTP)

OMH-licensed, OASAS-certified, and OMH and/or OASAS designated BH providers are reimbursed at the Medicaid government rate or higher for Medicaid-only reimbursable services. Continuous ongoing Medicaid-only services of care are reimbursed at the Medicaid rate or higher (i.e., "the government rate").

Comprehensive Psychiatric Emergency Program (CPEP) is an emergency service. Beacon/MAP Plans may not require prior authorization for CPEP.

Continuity of Care

Beginning January 1, 2023, and after, individuals enrolled in MAP can continue to see their behavioral health provider for a continuous episode of care for up to 24 months. "*Continuous Behavioral Health Episode of Care*" means a course of ambulatory behavioral health treatment, other than ambulatory detoxification and withdrawal services, that began prior to the effective date of the Behavioral Health Benefit Inclusion into MAP, and the services were provided:

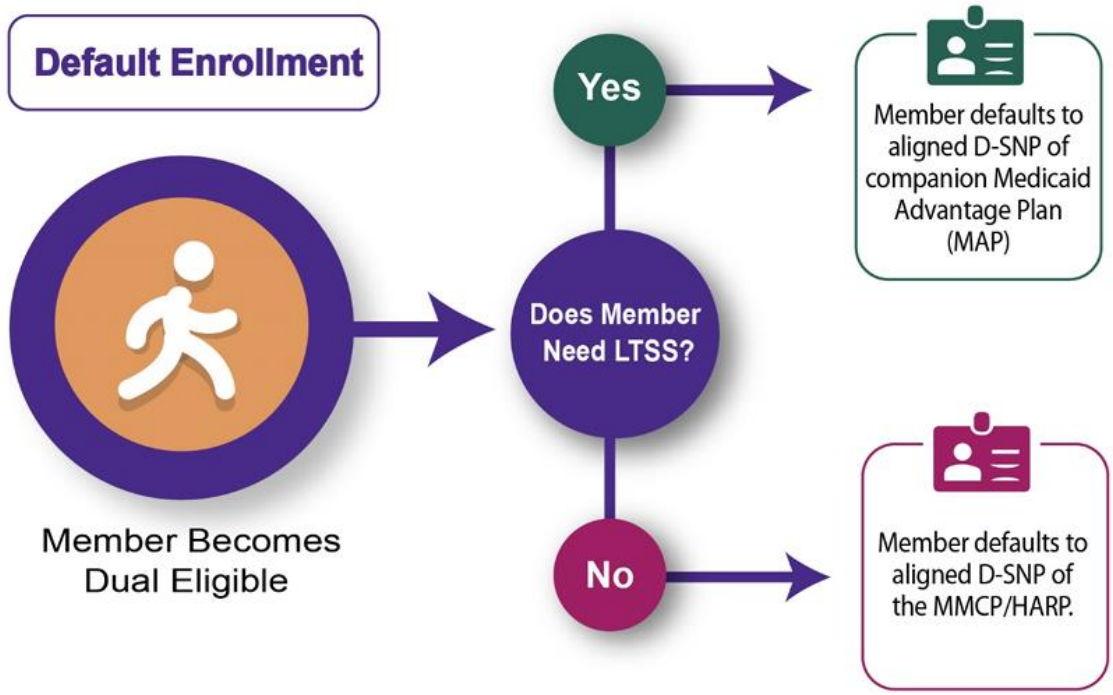
- In the same geographic service area
- At least twice during the six months preceding January 1, 2023
- By the same provider
- For the treatment of the same or related behavioral health condition

Streamlining Enrollment Pathways (Default Enrollment)

Default Enrollment is a CMS enrollment procedure whereby eligible Mainstream Medicaid Managed Care Plan (MMCP/)/HARP members *in need/receipt of LTSS* are seamlessly transferred to the organization's MAP and by default enrolled in the MAP-aligned D-SNP when they become Medicare eligible. In line with federal requirements, this process preserves member choice by allowing members to "opt-out" of Default Enrollment if they would prefer another option for their Medicare and Medicaid coverage.

Default Enrollment is a primary driver of increasing integrated care as in the past most newly dual Medicaid members would be disenrolled from their MMCP or HARP plan and exit to Medicaid FFS upon becoming Medicare eligible. In order to participate in Default Enrollment, MCOs must operate an MMCP or HARP product with an aligned D-SNP and successfully complete an application with CMS and DOH.

[Note: Medicaid members who are *not in need of LTSS* are also default-enrolled into an aligned Integrated Benefit D-SNP of their current Mainstream Medicaid Managed Care Plan (MMCP) or Health and Recovery Plan (HARP) as they first become Medicare eligible.



Source: New York State Dual Eligible Integrated Care Roadmap, March 2022

Training

Current providers must take DSNP Model of Care trainings.

Newly contracted providers will be trained to ensure they have appropriate knowledge, skills, and expertise, and receive technical assistance to comply with managed care requirements. This includes, but is not limited to, training on:

- Billing (including claims testing), coding, data interfaces and claiming resources/contacts, in alignment with the NYS Medicaid Advantage Plus Plans Behavioral Health Billing and Coding Manual.
- UM requirements and documentation requirements
- Evidence-based/promising practices and recovery principles