Office of Mental Health | Office of Addiction Services and Supports | Department of Health

KATHY HOCHUL, Governor | ANN MARIE T. SULLIVAN, M.D., Commissioner | CHINAZO CUNNINGHAM, MD, Commissioner | MARY T. BASSETT M.D., M.P.H., Commissioner

Behavioral Health Guidance for Managed Care Organizations Carving Behavioral Health into Medicaid Advantage Plus

The New York State Department of Health (DOH), Office of Mental Health (OMH) and Office of Addiction Services and Supports (OASAS) are working to integrate services for Medicaid and Medicare dually eligible individuals to streamline care and better treat individuals' needs holistically. One aspect of this integration is to carve additional Medicaid behavioral health (BH) services into the Medicaid Advantage Plus (MAP) product line benefit package, effective January 1, 2023. The full list of services being described in this guidance can be found in Appendix A, B, and C. Additional resources related to the behavioral health services that are carving in are included at the end of this guidance document. This will also allow individuals currently enrolled in a Mainstream, Health and Recovery Plan (HARP) or HIV Special Needs Plan product eligible for Medicare and who are in need of long-term services and supports to continue accessing BH services without disruption when moving to a MAP product.

New York State (NYS) is providing the following BH MAP guidance to inform Medicaid Managed Care Organizations (MMCOs) of the BH requirements to prepare for implementation.

The packet contains the following BH MAP requirements:

1.0 Behavioral Health Network Requirements and Appointment Availability Standards 2

2.0 Behavioral Health Staffing Requirements 8

3.0 Care Coordination Requirements 14

Appendix A: Combined Medicare Advantage and Medicaid Advantage Plus Benefit Package for Mental Health Services 16

Appendix B: Combined Medicare Advantage and Medicaid Advantage Plus Benefit Package for Substance Use Disorder Services 18

Appendix C: Combined Medicare Advantage and Medicaid Advantage Plus Benefit Package for Behavioral Health Services with Joint OMH and OASAS Oversight 19

In addition, NYS expects MMCOs with a MAP product line (MAP Plans) to comply with requirements outlined in the *New York State (State) Request for Qualifications for Adult Behavioral Health Benefit Administration: Managed Care Organizations and Health and*

Recovery Plans as appropriate for the services carving in January 1, 2023, except where explicitly noted in this document. MAP Plans will be expected to complete the Desk Review Tool which will outline specific document requests MAP Plans need to submit to the State to demonstrate readiness prior to January 1, 2023.

1.0 Behavioral Health Network Requirements and Appointment Availability Standards

Plans are obligated to have a network sufficient to meet enrollee needs. The following provisions apply to all MAP Plans regardless of size and enrollment numbers unless otherwise specified.

A. All MAP Plans must:

1. Contracting Requirements

i. Contract with clinics holding a State Article 31 and Article 32 license[1] for the full range of services available pursuant to that license.

ii. Offer contracts with all BH crisis intervention programs[2] within the MAP Plan service area.

iii. Offer contracts to all BH providers seeing five or more of their enrollees in the Plan's service area based on the initial list provided by the State and continue to monitor out of network single case agreements to identify any additional providers seeing five or more of their enrollees and offer contracts as appropriate for 24 months.

iv. Ensure individuals enrolled beginning January 1, 2023, and after can continue to see their BH provider for a continuous episode of care[3] for up to 24 months. This includes allowing HARP eligible enrollees to continue accessing the same Health Home provider and not requiring enrollees to change Health Homes at the time of the transition.

v. Accept the State-issued CORE designation in place of, and not in addition to, any MAP Plan credentialing process for individual employees, subcontractors, or agents

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[1] The list of behavioral health providers can be found in Provider Network Data System (PNDS).

[2] BH Crisis Intervention programs include mobile crisis, crisis residence, and when available, crisis stabilization. The State will provide a monthly updated list of crisis intervention providers via Health Commerce System (HCS).

[3] "Continuous Behavioral Health Episode of Care" means a course of ambulatory behavioral health treatment, other than ambulatory detoxification and withdrawal services, which began prior to the effective date of the Behavioral Health Benefit Inclusion into MAP in the geographic service area in which services had been provided to an enrollee 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.

of such providers when credentialing Community Oriented Recovery and Empowerment (CORE) Service providers. The MAP Plan shall still collect and accept program integrity related information from these providers and shall require that such providers not employ or contract with any employee, subcontractor or agent who has been debarred or suspended by the federal or state government, or otherwise excluded from participation in the Medicare or Medicaid program.

vi. Accept OMH and OASAS licenses, operation, designation, and certifications in place of, and not in addition to, any Contractor credentialing process for individual employees, subcontractors, or agents of such providers when credentialing OMH-licensed, OMH-operated, OMH-designated, or OASAS-certified providers, the MAP Plan shall. The MAP Plan shall still collect and accept program integrity related information from these providers and shall require that such providers not employ or contract with any employee, subcontractor or agent who has been debarred or suspended by the federal or state government, or otherwise excluded from participation in Medicare or Medicaid.

vii. Offer contracts to all OASAS Opioid Treatment Program providers within the counties in the MAP Plan's service area.

viii. Update and maintain their provider manual to include all relevant information on BH services and BH-specific provider requirements as applicable to the MAP product line. New York State will provide guidance for this requirement at a later date.

2. Reimbursement Requirements

i. Reimburse non-participating Comprehensive Psychiatric Emergency Program (CPEP) providers at the same rate as participating providers. CPEP is an emergency service; MAP Plans may not require prior authorization for CPEP.

ii. Reimburse any BH crisis intervention program, regardless of network status. Payment for crisis intervention services by non-participating providers will be at the same rate as for participating providers.

iii. Reimburse participating and non-participating OMH-licensed, OASAS-certified, and OMH and/or OASAS designated BH providers at the Medicaid government rate or higher for Medicaid-only reimbursable services. The government rate reimbursement floor is mandated until March 31, 2027, pending further extension.
- Continuous ongoing Medicaid-only services of care must be reimbursed at the Medicaid rate or higher (i.e., "the government rate").

B. MAP Plans without an affiliated Mainstream/HARP product must also:

i. Conduct provider training for newly contracted BH providers 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:

a. 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.*
b. UM requirements and documentation requirements.
c. Evidence-based/promising practices and recovery principles.

C. BH Network Standards for MAP Plans with More Than 1,000 Enrollees

MAP Plans with more than 1,000 enrollees must meet all network and appointment availability standards for benefits listed in the table below. At least fifty percent (50%) of the network standards for each service must be met by January 1, 2023. It is expected MAP Plans will meet 100 percent of network requirements by January 1, 2024. MAP Plans must execute Single Case Agreements with any providers where there are network gaps for services between January 1, 2023, through January 1, 2024. These requirements apply to the MAP Plan's service area.

MAP Plans with fewer than 1,000 enrollees must monitor their enrollment. At such time that enrollment exceeds 1,000 enrollees the MAP Plan must meet network adequacy requirements described in section 1.0 A within six months.

Table 1: MAP Minimum Network Standards by Service Type

Service	Requirement
OMH[4]	
OMH Outpatient Clinic (previously carved in)	50% of clinics or a minimum of two clinics per county, whichever is greater[5][6]
State Operated Outpatient Programs (carved in)	TBD- State guidance will be forthcoming

[4] The list of behavioral health providers can be found in Provider Network Data System (PNDS).

[5] Before January 2023, the minimum network requirement for OMH outpatient clinic in PNDS is two per county. This will be changed to 50% or 2 whichever greater for MAP Plans with more than 1000 enrollees beginning January 2023.

[6] To ensure enrollee choice, such clinics must be operated by no fewer than two distinct provider agencies, if available in the Plan's service area. The network must include clinic providers that offer urgent and non-urgent same day, evening, and weekend services. Where an authorized integrated outpatient service provider is in the Plan's network, the Plan shall contract for the full range of integrated outpatient services provided by such provider.

Personalized Recovery Oriented Services (PROS) or Continuing Day Treatment (CDT) [7]	50% of all such providers or two providers per county, whichever is greater
Assertive Community Treatment (ACT)	Two per county
Partial Hospitalization	Two per county
Inpatient Psychiatric Services	Two per county
Comprehensive Psychiatric Emergency Program (CPEP & 9.39 Emergency Rooms)	Two per county
Mobile Crisis	All in county
Crisis Residence	All in county
OASAS	
Opioid Treatment Programs	All in county
Inpatient Rehabilitation Part (IPR) 818 Treatment[8]	Contract with all OASAS Addiction Treatment Centers (ATCs) AND per county, two other IPR providers (where possible) including one freestanding provider (where possible)
Part 816 Detoxification including Inpatient Hospital Detoxification, Inpatient Medically Supervised Detoxification[9]	Two per county (one hospital based and one freestanding where possible)
Part 816 Medically Supervised Outpatient Withdrawal (carved in)	Two per county (where possible)
OASAS Outpatient Clinic (previously carved in)	50% of clinics or a minimum of two clinics per county, whichever is greater
Outpatient Rehabilitation (carved in)	50% of clinics or a minimum of two clinics per county, whichever is greater
Part 820 Residential Services	All in county

[7] PROS contracts should be for at least two per county or 50%, whichever is greater. In counties without two PROS programs, CDT can be substituted for one.

[8] Previously the benefit package included only those OASAS certified Inpatient Rehabilitation that were operated by hospitals. The expanded benefit will now also include freestanding / community based, non-hospital inpatient rehabilitation programs including OASAS operated Addiction Treatment Centers (ATCS).

[9] Previously the benefit package included only Inpatient Medically Supervised Detoxification that were operated by hospitals. The expanded benefit will now also include freestanding / community based non-hospital Medically Supervised detoxification programs.

Buprenorphine prescribers	All authorized prescribers serving Medicaid patients in MAP Plan service area or provide single case agreements.
OMH/OASAS	
Community Oriented Recovery and Empowerment (CORE) Services	Two Providers of each CORE Service per County, as available.
Crisis Stabilization	Plans must comply with future State issued guidance.
BH providers that serve five or more Plan enrollees (based on list distributed by NYS)	100% in MAP Plan service area.

Table 2: Appointment Availability Standard by BH Service Type

Service Type	Emergency	Urgent	Non-urgent MH/SUD	BH Specialist	Follow-up to emergency or hospital discharge	Follow-up to jail/prison discharge
MH Outpatient Clinic (including Licensed BH Practitioner)/PROS Clinic		Within 24 hrs. of request	Within 1 wk.		Within 5 days of request	Within 5 days of request
ACT		Within 24 hrs. of request			Within 5 days of request	
PROS		Within 24 hrs. of request		Within 2 wks.	Within 5 days of request	Within 5 days of request
Continuing Day Treatment (CDT)				2-4 wks.		Within 5 days of request

Partial Hospitalization					Within 5 days of request	
Comprehensive Psychiatric Emergency Program (CPEP)	Upon presentation					
Crisis Intervention (Mobile Crisis, Crisis Residence, Crisis Stabilization)	Upon presentation	Within 24 hours for crisis residence			Immediate	
OASAS Outpatient Clinic		Within 24 hrs. of request	Within 1 wk. of request		Within 5 days of request	Within 5 days of request
Detoxification	Upon presentation					
SUD Inpatient Rehab	Upon presentation	Within 24 hrs. of request				
Opioid Treatment Program		Within 24 hrs. of request			Within 5 days of request	
OASAS Part 820 Residential Services		Within 24 hrs. of request		2-4 wks.	Within 5 days of request	
CORE Services[10]- Psychosocial Rehabilitation (PSR), Community Psychiatric Support and			Within 2 weeks of request		Within 5 days of request or as	Within 5 days of request or as

[10] Additional information about the CORE services can be found online at: https://omh.ny.gov/omhweb/bho/core/

Treatment (CPST), Family Support and Training (FST)					clinically indicated	clinically indicated
CORE Services-Peer Supports		Within 24 hrs. of request	Within 1 week of request		Within 5 days of request	

2.0 Behavioral Health Staffing Requirements

MAP Plans must manage the BH benefits and meet the needs of enrollees with serious mental illness, substance use issues, and/or co-occurring physical health challenges. MAP Plans must therefore submit materials to NYS demonstrating they have the personnel and structural capacity to ensure the delivery of effective BH care. The following provisions apply to all MAP Plans regardless of size and enrollment numbers unless otherwise specified.

A. MAP Plans must comply with Contract Personnel Sections 3.3 A, D, H, and M of the *New York Request for Qualifications (RFQ) for Adult Behavioral Health Benefit Administration: Managed Care Organizations and Health and Recovery Plans.*

B. MAP Plans must meet BH Staffing Requirements as follows:

   1. Health Plans offering MAP that also have an existing Mainstream MMCO, HARP and/or HIV-Special Needs Plan-must attest the MMCO and/or HARP BH Key and Managerial Personnel will manage all MAP enrollee BH services. MAP Plans must submit a narrative describing how staff will collaborate across business lines to address MAP enrollee BH needs. If the MAP Plan intends to meet the below requirements in sections 2 and 3 in a different way than outlined above, the MAP Plan must provide a narrative describing their method of managing BH personnel.

2. Health Plans offering MAP that do not have an affiliated MMCP, HARP or HIV-Special Needs Plan, or those not using existing health plan staff, with more than 4,000 enrollees meeting HARP target criteria and risk factors[11] must:
   i. Employ the following Personnel at a 1.0 FTE dedicated to MAP:
      a. BH Medical Director
      b. BH Clinical Director
      c. Manager(s) to fulfill BH Care Management (CM) and BH Utilization Management UM functions defined below in **BH Personnel Requirements.**
   ii. Submit BH Medical Director and BH Clinical Director résumés to ensure appropriate experience and license requirements are met as defined below in **BH Personnel Requirements**.
   iii. In addition to RFQ requirements regarding personnel vacancies, MAP Plans must notify NYS of key BH CM and/or UM personnel changes or if positions(s) become vacant within seven calendar days. MAP Plans must direct these notifications to:
      - Office of Mental Health BHO Mailbox: BHO@omh.ny.gov
      - Office of Addiction Services and Supports BH MMC Mailbox: OASAS.SM.BehavioralHealthMMC@oasas.ny.gov, and
      - MLTC Plan Managers

3. MAP Plans without an affiliated MMCP, HARP or HIV- Special Needs Plan, with fewer than 4,000 enrollees meeting HARP target criteria and risk factors can either comply with #2 above or submit an alternate staffing plan detailing how the MAP Plan will address BH CM and UM requirements defined below in **BH Personnel Requirements**.
   i. MAP Plans must notify NYS when a State-approved alternate staffing plan is revised, including changes to, or vacancies in, key BH CM and/or UM personnel. Notifications should be directed to:
      - Office of Mental Health BHO Mailbox: BHO@omh.ny.gov,
      - Office of Addiction Services and Supports BH MMC Mailbox: OASAS.SM.BehavioralHealthMMC@oasas.ny.gov, and
      - MLTC Plan Managers

C. MAP Plans must submit organizational chart(s) clearly outlining how BH staff will be integrated into existing organizational structures.

[11] MAP enrollees meeting HARP target criteria and risk factors will be identified by an RRE code.

D. MAP Plans must explain how BH expertise[12] is incorporated into the Interdisciplinary Care Team to demonstrate coordination with physical health and long-term care management.

E. MAP Plans must ensure staff are trained in accordance with the **MAP Plan Staff Training Requirements** on page 14.

BH Personnel Requirements:

A. **BH Medical Director**: This individual must hold a NYS license as a physician and shall have a minimum of five years of experience working in BH managed care settings or BH clinical settings (at least two years must be in a clinical setting). The Plan BH Medical Director shall have appropriate training and expertise in general psychiatry and/or addiction disorders (e.g., board certification in general psychiatry and certification in addiction medicine or certification in the subspecialty of addiction psychiatry). This individual must be located in NYS.

B. **BH Clinical Director**: This position must be reflected in the Plan's organizational chart and the identified individual must have appropriate managerial experience. The individual shall hold a NYS license as a BH professional[2] and have at least seven years of experience in a BH managed care setting or BH clinical setting, including at least two years of managed care experience (preferably Medicaid managed care). This individual must be located in NYS.

C. The BH Medical Director and Clinical Director shall be involved in the following functions:
   1. Development, implementation, and interpretation of clinical-medical policies and procedures specific to BH or which can be expected to impact the health and recovery of BH consumers.
   2. Ensuring strong collaboration and coordination between physical and BH care.
   3. Clinical peer review recruitment and supervision.
   4. Provider recruitment, education, training, and orientation.
   5. Decision-making process for BH provider credentialing decisions.
   6. BH provider quality profile design and data interpretation.

[12] BH expertise must be provided by a BH Professional. BH Professional is defined on page 29 of the RFQ.

7. Development and implementation of the BH sections of the Quality Management (QM)/Utilization Management (UM) Plan, including having the BH medical director participate in QM committees.
8. Administration of all BH QM/UM and performance improvement activities, including grievances and appeals.
9. Attendance at regular (at least quarterly) Plan leadership and medical director meetings designated by the State BH contract manager.

D. **BH Care Management and BH Utilization Management Managerial Positions:**

1. **BH care management**: Plans shall provide CM to individuals with Serious Mental Illness (SMI), Substance Use Disorder (SUD), co-occurring physical health, co-occurring disorders of MH and SUD, and co-occurring MH and/or SUD disorders and Intellectual and Developmental Disability (I/DD) in collaboration with Health Homes when appropriate. This individual must be a U.S. based BH professional with experience working in a BH managed care setting or BH clinical setting and must work at sites located in NYS.
2. **BH utilization management**: Plans shall provide UM to individuals with SMI, SUD, co-occurring physical health, co-occurring disorders of MH and SUD, and co-occurring MH and/or SUD disorders and I/DD. This individual must be a U.S. BH professional with experience working in a BH managed care setting or BH clinical setting and knowledge of BH rehabilitation and recovery services. This position may work at sites located outside NYS.
3. The BH CM and UM managerial positions above must comply with the following requirements:

   i. Mental Health Services: All managerial staff must demonstrate knowledge (or describe a plan to recruit individuals with knowledge) of the full range of NYS MH services, programs, and requirements. Ideally, the Plan should employ manager(s) with experience working in NYS BH settings that provide recovery-oriented services to individuals with serious BH conditions (e.g., Personalized Recovery Oriented Services, peer services, housing supports, Assertive Community Treatment, and supported employment). Managers should have knowledge of or experience with delivering research-based and evidence-based practices (EBP) for adults in clinical and/or recovery-oriented settings.

ii. Addictions Services: Plans shall demonstrate managerial knowledge (or describe a plan to recruit individuals with knowledge) of the full range of SUD services available to NYS Medicaid enrollees in one or more of the departments listed below. Ideally, the Plan should employ an individual at the manager level who meets the requirements for a Credentialed Alcoholism and Substance Abuse Counselor (CASAC) in good standing with OASAS and who has at least three years of experience in BH and a Master's degree. Additionally, expertise is required in the special needs of adults with a serious SUD with or without co-occurring mental illness. Managers should have knowledge of or experience with delivering research based and EBP for adults in clinical and/or recovery-oriented settings.

MAP Plan Staff Training Requirements

Training Topic	Clinical Staff (UM/CM)	Member Services	Provider Relations
New York State's vision, mission, goals, operating principles for BH	☑	☑	☑
New BH services	☑	☑	☑
BH service eligibility requirements and protocols	☑	☑	☑
Services for individuals with first episode psychosis	☑	☑	
Evidence-based practices	☑		☑
Recovery principles	☑		☑
BH/medical integration; co-occurring BH and medical disorders; integrated care management principles	☑	☑	☑
Authorization requirements and level of care guidelines for new BH services	☑		
Network and access standards for new BH services	☑	☑	☑
After hours and crisis triage protocols	☑	☑	☑
Linkage requirements (i.e., with social services, non-Medicaid BH services, domestic violence services, Consumer Directed Personal Assistance Program, NYS Medicaid Ombudsman programs, etc.)	☑	☑	☑
Cross training for specialty BH, physical health and long-term care in treatment approaches and illness progression to ensure training outside their specialties	☑		

3.0 Care Coordination Requirements

MAP Plans must:

A. Comply with the following sections of the *New York Request for Qualifications (RFQ) for Adult Behavioral Health Benefit Administration: Managed Care Organizations and Health and Recovery Plans*:
   1. Utilization Management– Section 3.9 A-P, with the following exceptions:
      i. Section 3.9 B: The Table 1 referenced in 3.9 B is outdated. Please refer to the Utilization Management section of the OMH BHO Policy Guidance webpage and the Medicaid Managed Care Crisis Intervention webpage for the list of BH services covered by MAP Plans.
      ii. Section 3.9 O: The Section 3.3 requirements referenced in 3.9 O do not apply to MAP Plans. This is superseded by the MAP BH Staffing Requirements in section 2.0 of this packet.
   2. Clinical Management – Section 3.10 B-G, with the following exception:
      i. Section 3.10 E: The referenced requirement for BH Medical Director participation is only applicable to a Health Plans that offers MAP as well as a Mainstream Medicaid Managed Care Plan, Health and Recovery Plan and/or HIV Special Needs Plan, or MAP-only Plans with more than 4,000 enrollees meeting HARP target criteria and risk factors[13].

B. Comply with State-issued guidance for BH service administration, including future State-issued Crisis Stabilization Center guidance, pending Centers for Medicare and Medicaid Services approval.

C. Plans may use NYS approved UM protocols, in compliance with parity laws and NYS policy, to review duration and intensity of an episode of care.
   1. These may be applied to the newly carved-in BH services that do have previously issued NYS utilization review criteria guidance after the first 90 days following the inclusion of BH benefits to MAP Plans.
   2. These may be applied after the first 90 days post new enrollment, following the inclusion of BH benefits to MAP Plans for a period of 24 months.

D. MAP Plan will integrate BH services and BH considerations into the existing MAP Plan care management structure. This must encompass:

[13] MAP enrollees meeting HARP target criteria and risk factors will be identified by an RRE code.

1. Inclusion of BH services in MAP Plan care management responsibilities, including referral, assistance in or coordination of services for an enrollee to obtain needed BH services, irrespective of whether the needed services are included in the MAP Benefit Package.
2. Process for enhanced coordination between specialty BH staff and primary care physicians and long-term care providers serving patients living with serious mental illness, addiction, and co-occurring physical health/long term care needs. This process must include the ability for BH CM and UM managers to access an enrollee's BH, physical health, and long-term care records and service usage, as necessary to meet the enrollee's needs to the extent allowed by law and regulation.
3. Process for cross-training specialty BH, physical health and long-term care staff in treatment approaches and illness progression, enabling all staff to receive training outside their specialties.
4. Training and support for long term care providers serving individuals with BH needs, including those with Serious Mental Illness (SMI) and Substance Use Disorder (SUD).
5. Coordination of all enrollee care management activities, including internal care management, Health Home, and any other service care managers, to reduce redundancy and assure accurate information sharing.
6. Process to ensure enrollees with Assisted Outpatient Treatment (AOT) court orders are easily identified in the MAP Plan's electronic record by UM and CM staff and the treatment aspects of the Court Order are addressed in the enrollees Plan of Care. Plans are expected to coordinate care with AOT court ordered service providers.
7. Process to ensure that enrollee plans of care (POCs) include BH need and use a whole-person oriented, person-centered planning approach with health education/health promotion services in accordance with section 10.13 of the MAP Model Contract.
8. Process to notify enrollees newly eligible to receive CORE Services upon meeting HARP target criteria and risk factors.

E. Adopt, disseminate, and implement the clinical practice guidelines listed below as well as nationally recognized clinical practice guidelines and other evidence-based and promising practices.
   1. Substance Abuse and Mental Health Services Administration (SAMHSA)'s ACT
   2. SAMHSA's Illness Management and Recovery
   3. SAMHSA's Integrated Dual Disorder Treatment for Co-occurring Disorders
   4. SAMHSA's Family Psychoeducation

5. Tobacco cessation
6. OMH First Episode Psychosis practice guidelines
7. Seeking Safety
8. Motivational Enhancement Therapy
9. Twelve- Step Facilitation
10. Cognitive Behavioral Therapy for SUD
11. Medication Assisted Treatment for SUD
12. Other SUD EBP as recognized by SAMHSA

F. Develop and implement a system to enable UM/CM staff to identify high-risk enrollees. UM/CM staff must address high-risk enrollees BH and social determinants of health needs through care coordination.
   1. At minimum, the system should include the following criteria to identify high-risk enrollees:
      i. Enrollees meeting HARP target criteria and risk factors identified by an RRE code
      ii. Enrollees with a current or expired (within the prior five years) AOT order
      iii. Discharge from a State Psychiatric Hospital, State Community Residence, or Adult Home
      iv. New onset psychosis
      v. Homelessness
      vi. Homebound
      vii. Frequent psychiatric inpatient or detox usage
      viii. Discharge from psychiatric inpatient unit at a general hospital
      ix. Discharge from an emergency department for a BH-related condition
      x. Use of a BH crisis service
      xi. History of suicide attempt
      xii. Other criteria determined to indicate high risk

Appendix A: Combined Medicare Advantage and Medicaid Advantage Plus Benefit Package for Mental Health Services

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Combined Medicare Advantage and Medicaid Advantage Plus Benefit Package for Mental Health Services

OMH Service	OMH Regulation	Medicaid Coverage (Before Jan 2023)		Medicaid Coverage (After Jan 2023)		Medicare Coverage	
		Hospital	Freestanding	Hospital	Freestanding	Hospital	Freestanding
Psychiatric Inpatient	Parts 580, 582, and 587	Covered (days in excess of the Medicare 190-day lifetime maximum)		Covered		Covered (Medicare 190-day lifetime maximum)	
Mental Health Outpatient Treatment and Rehabilitative Services	Part 599	Covered	Covered	Covered	Covered	Covered	Covered
Assertive Community Treatment (ACT)	Part 508	Carved-out		Covered		Not Covered	
Continuing Day Treatment (CDT)	Sections 587.10 & 588.7	Carved-out		Covered		Not Covered	
Comprehensive Psychiatric Emergency Program (CPEP)	Parts 590 & Part 591	Carved-out		Covered		Not Covered	
Partial Hospitalization (PH)	Sections 587.12 & 588.9	Carved-out		Covered		Not Covered	
Personalization Recovery Oriented Services (PROS)	Part 512	Carved-out		Covered		Not Covered (except for the clinic component)	
Crisis Intervention (Mobile Crisis, Crisis Residence)	Crisis Residence: Part 589	Carved-out		Covered		Not Covered	

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Appendix B: Combined Medicare Advantage and Medicaid Advantage Plus Benefit Package for Substance Use Disorder Services

Combined Medicare Advantage and Medicaid Advantage Plus Benefit Package for Substance Use Disorder Services							
OASAS Service	**OASAS Regulation**	**Medicaid Coverage (Before Jan 2023)**		**Medicaid Coverage (After Jan 2023)**		**Medicare Coverage**	
		Hospital	**Freestanding**	**Hospital**	**Freestanding**	**Hospital**	**Freestanding**
Medically Managed Detox - Inpatient	Section 816.6	Covered		Covered		Covered	
Medically Supervised Detox - Inpatient	Section 816.7	Covered	Carved-out	Covered	Covered	Covered	Not Covered
Medically Supervised Detox - Outpatient	Section 816.8 and Part 822	Covered	Covered	Covered	Covered	Covered	Not Covered
Inpatient Rehabilitation	Part 818	Covered	Carved-out	Covered	Covered	Covered	Not Covered
Addiction Treatment Center - State Operated Inpatient Rehabilitation	Part 818		Carved-out		Covered		Not Covered
Residential Services	Part 820		Carved-out		Covered		Not Covered
Outpatient Clinic	Part 822	Covered	Covered	Covered	Covered	Not Covered	Not Covered
Outpatient Rehabilitation	Part 822	Covered	Covered	Covered	Covered	Not Covered	Not Covered
Opioid Treatment Program	Part 822	Carved-out	Carved-out	Covered	Covered	Covered	Covered

Appendix C: Combined Medicare Advantage and Medicaid Advantage Plus Benefit Package for Behavioral Health Services with Joint OMH and OASAS Oversight

Combined Medicare Advantage and Medicaid Advantage Plus Benefit Package for Behavioral Health Services with Joint OMH and OASAS Oversight							
OMH and OASAS Service	**OMH/OASAS Regulation**	**Medicaid Coverage (Before Jan 2023)**		**Medicaid Coverage (After Jan 2023)**		**Medicare Coverage**	
		Hospital	**Freestanding**	**Hospital**	**Freestanding**	**Hospital**	**Freestanding**
Community Oriented Recovery and Empowerment (CORE) Services	N/A		Carved-out		Covered	Not Covered	
Crisis Stabilization Centers	Part 600		Carved-out		Covered	Not Covered	

NYS has partnered with the Managed Care Technical Assistance Center (MCTAC) to host webinars related to this transition. The behavioral health services carving into the MAP benefit package are described in the webinars listed below, along with additional information for MAP Plans.

- Overview of Behavioral Health Carve-In to Medicaid Advantage Plus (MAP)
- Behavioral Health Carve-In to Medicaid Advantage Plus (MAP): MCO Readiness
- Behavioral Health Carve-In to Medicaid Advantage Plus (MAP): Medical Necessity Criteria Review for MAP Plans
- Behavioral Health Carve-In to Medicaid Advantage Plus (MAP) Updated Guidance & Readiness Review Process