Transitioning Adult Behavioral Health Services Into Medicaid Managed Care: Mental Health Contractual Provisions as of September 10, 2015

Expansion of the Medicaid Managed Care Benefit Package

Effective October 1, 2015 in New York City, and July 1, 2016 in the rest of the state, the following mental health programs and services will become covered benefits for ALL Medicaid Managed Care enrollees age 21 and over. Prior to the expansion of the benefit package, the mental health services covered by Medicaid Managed Care were inpatient psychiatric services in Article 28 facilities and Part 599 clinics services for non-SSI recipients.

Covered services will now include:

- Inpatient psychiatric services in Article 28 facilities
- Part 599 clinics services
- Behavioral health services in Part 598 integrated clinics
- Personalized Recovery Oriented Services (PROS) programs operated under Part 512
- Continuing Day Treatment (CDT) programs operated under Part 587
- Intensive Psychiatric Rehabilitation Treatment (IPRT) programs operated under Part 587
- Assertive Community Treatment (ACT) programs operated under Part 508
- Partial Hospitalization (PH) programs operated under Part 587
- Inpatient Psychiatric Hospitalization Services operated under Parts 580 or 582
- Comprehensive Psychiatric Emergency Programs (CPEPs) operated under Part 590
- Crisis Intervention
- Behavioral Health Home and Community Based Services (BHHCBS): available to eligible Health and Recovery Plan (HARP) and HARP-eligible HIV Special Needs Plan (SNP) enrollees only

With the upcoming transition, New York State (NYS) has provided Medicaid Managed Care plans with specific legal requirements and accompanying guidance regarding the process of entering into agreements with providers of these services.

Contractual Provisions

- New York State (NYS) is incorporating several key provisions into the Medicaid Managed Care Model contract that address:
    - Ensuring Medicaid Managed Care plans establish adequate behavioral health provider networks;
    - Promoting financial stability through payment and claiming requirements; and
    - Supporting access to and removing barriers to mental health treatment and recovery services.

- The Medicaid Managed Care Model Contract is being amended to reflect the expansion of covered benefits and to include the additional behavioral health services. The Medicaid provisions of provider agreements with the Medicaid Managed Care plans may need to be written or amended to reflect these requirements.
- The Medicaid Managed Care Model Contract provisions are applicable to only Medicaid Managed Care, HARP, and HIV SNP lines of business. Note that the proposed contract amendment is subject to review and approval by the Centers for Medicare and Medicaid Services (CMS). Because a number of clinics treat individuals with co-occurring disorders, provisions related to Substance Use Disorder medication access are highlighted in Attachment A as well.
- OMH providers are encouraged to review current and proposed amendments to provider agreements for consistency with the proposed Medicaid Managed Care Model Contract provisions outlined in Attachment A.
- Providers are **strongly** encouraged to finalize contracting with plans to ensure inclusion in Medicaid Managed Care provider networks prior to the effective date of the behavioral health benefit expansion.

ATTACHMENT A
Contract Requirements and Statute (where noted)

Topic / Policy	Section	BENEFIT PACKAGE REQUIREMENTS
BH Self - referrals	10.15 (a)(i)	Enrollees may obtain unlimited self-referrals for mental health and Substance Use Disorder assessments from participating providers without requiring preauthorization or referral from the enrollee's Primary Care Provider. This provision does not apply to ACT, inpatient psychiatric hospitalization, partial hospitalization and BH Home and Community Based Services.
Utilization Management (UM) and Level of Care Determinations	10.21 (a)	Service Authorization Determinations for mental health services must be made in accordance with utilization management criteria and level of care guidelines issued and/or approved by the Office of Mental Health.
Alternate Level of Care	10.21(c)	If the plan determines that an alternate level of care is appropriate, but has not identified an appropriate provider of such care (either in network or out of network), the plan must continue to approve coverage of and continue to reimburse for services provided by the current provider.
Ambulatory Patient Groups (APG)/Fee for Service (FFS) Rate Mandate	10.21 (d)	Government rates for 24 months from effective date of BH inclusion. For mental health, this **only** applies to OMH licensed ambulatory mental health services. NOTE: For clinics, this is also required per Section 13 of Part C of chapter 60 of the laws of 2014 amending Section 48-a of part A of chapter 56 of the laws of 2013 amending chapter 59 of the laws of 2011 amending the public health law and other laws.
Continuity of Care Requirements	10.21 (e)	2 year continuity of care language affirms plans must permit enrollees to continue receiving services from their current provider(s) for "Continuous Behavioral Health Episodes of Care" (as defined in the Model Contract) for up to 24 months from the date of the Behavioral Health benefit inclusion in either NYC or the rest of state, respectively. Notwithstanding, plans may use OMH-approved UR criteria to review duration and intensity of such episodes of care.
	10.21 (f)	90 day transition language prohibits plans from applying utilization review criteria for a period of 90 days from the effective date of the Behavioral Health benefit inclusion in either NYC or the rest of state, respectively. Accordingly, plans must accept existing plans of care.
BH Pharmacy	10.32	Except where otherwise prohibited by law, pharmacy services

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Access		include immediate access / no prior authorization language for BH prescribed drugs 72 hour supply generally; and 7 day supply for prescribed drug or medication associated with the management of opioid withdrawal and / or stabilization.
OMH Certification Meets Credential Requirements	21.4 (b)	Directs the plan to credential the OMH licensed and OASAS certified program and that the license / certification shall suffice for plan contracting requirements and that the plan may not separately credential individual staff members. The contract requires that the plans shall still collect, accept, and review Medicaid program integrity related information as required by the State Contract and Medicaid regulations.
BH HCBS Designation Meets Plan Credential Requirements.	21.4 (d)	HARP and HIV SNP only provision that directs the plan to accept the NYS BH HCBS designation to satisfy the plans BH HCBS credentialing; plan may not separately credential a provider's staff members; and affirms that contractor shall still collect and accept program integrity related information as required by the State Contract and Medicaid regulations.
Primary Care in OMH Programs /PCPs	21.14 (e)	Adding PCPs employed by OMH and OASAS clinic programs as eligible primary care providers. The enrollee must choose or be assigned a specific provider or provider team within the clinic to serve as his/her PCP. All PCPs employed by clinics must meet the same plan credentialing standards as any other PCP in the plan's network.
5 or more for members	21.19 (a)(ii)	Prior to the date of BH inclusion in the Medicaid benefit, plans must offer to contract with any OMH or OASAS providers with five or more active plan members. This list is provided to the plans by NYS and the requirement is for 24 months from the date of the Behavioral Health benefit inclusion in either NYC or the rest of state, respectively.

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Part 599 Clinics (other than State-operated clinics) and Part 598 integrated clinics	21.19 (b) (i) (A)	At a minimum, the plan's network must include: • 50% of all clinic sites or a minimum two clinic sites per county, whichever is greater; • 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. • 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. Additional providers may be necessary to demonstrate network adequacy.
PROS programs operated under Part 512, Continuing Day Treatment programs operated under Part 587, and IPRT programs operated under Part 587	21.19 (b)(i) (B)	At a minimum, the plan's network must include: • For urban counties: network must include 50% of all such providers or two providers per county, whichever is greater. • For rural counties: network must include 50% of all such providers or two providers per region, whichever is greater. Additional providers may be necessary to demonstrate network adequacy.
ACT programs operated under Part 508	21.19 (b) (i)(C)	At a minimum, the plan's network must include: • For urban counties: network must include two providers per county. • For rural counties: network must include two providers per region. Additional providers may be necessary to demonstrate network adequacy.
Partial Hospitalization programs operated under Part 587	21.19 (b)(i)(D)	At a minimum, the plan's network must include: • For urban counties: network must include two providers per county. • For rural counties: network must include two providers per region. Additional providers may be necessary to demonstrate network adequacy.

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Inpatient Psychiatric Hospitalization Services operated under Parts 580 or 582	21.19 (b)(i)(E)	At a minimum, the plan's network must include: • For urban counties: network must include two providers per county • For rural counties: network must include two providers per region. Additional providers may be necessary to demonstrate network adequacy.
Comprehensive Psychiatric Emergency Programs operated under Part 590	21.19 (b)(i)(F)	At a minimum, the Plan's network must include: • For urban counties: network must include two providers per county • For rural counties: network must include two providers per region. Additional providers may be necessary to demonstrate network adequacy.
Crisis Intervention	21.19 (d)	The Contractor's network must include an adequate number of Crisis Intervention service providers in accordance with the State issued Guidance
State-operated ambulatory mental health services and State-operated providers of Behavioral Health Home and Community Based Services	21.19 (e)	The Contractor's network must include all State-operated providers in each region that contains a county within the plan's service area
APG reimbursement	21.19 (f)	This provision reaffirms the APG reimbursement requirement for outpatient mental health and Substance Use Disorder services in various settings citing the relevant statutory authority.
All products prohibition language	NEW 22.3 (b)	The contractor is prohibited from conditioning the participation of a BH provider upon agreement to participate in a Contractor's non-Medicaid line(s) of business.
Alternative Payments Permission	22.5 (k)	Requirement that for BH providers, proposed alternative payment arrangements must be submitted to and approved by OMH / OASAS, as applicable.
Two year Contract	22.5 (l)	For OMH or OASAS providers with five or more active plan members, with whom plans are required to contract, this provision requires the Contractor to include language in the

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		provider contract that the contract is minimum two year term and that the contractor will pay the applicable Medicaid fee-for-service rate.
No prior authorization	No prior authorization Appendix F	The Contractor shall not require prior authorization for either urgent or non-urgent ambulatory services delivered by: OASAS certified Part 822 outpatient clinics (including intensive outpatient services), outpatient rehabilitation and opioid treatment programs, OASAS certified Part 816 medically supervised outpatient withdrawal and stabilization programs, OMH Part 599 licensed outpatient clinics (including community mental health services), OASAS Part 825 integrated clinics, OMH Part 598 integrated clinics and Title 10 Part 404 Diagnostic and Treatment Centers.[1]
Access to drugs used for SUD treatment on both medical benefit and formulary	SUD medication Appendix K, #10	Drugs used for the treatment of Substance Use Disorders are covered by the contractor: consistent w / FDA labeling and compendia; include medications for SUD opioid dependency in the formulary; at least one formulation of buprenorphine and buprenorphine / naloxone; Vivitrol covered as a medical and a pharmacy benefit. Language affirms that Naloxone is available in atomizers in addition to: vials; prefilled syringes and auto injectors
Access to long-acting injectable on both medical benefit and formulary	MH medication Appendix K, #10	Long-acting injectable medications must be covered by the Contractor as a medical and pharmacy benefit. The Contractor's clinical criteria for coverage for long acting antipsychotic injectable medication quantity/dose/age limits shall be consistent with FDA approved labeling and Official Compendia.
Smoking Cessation	Appendix K, #11	Unlimited courses of smoking cessation products are available for enrollees with one or more Substance Use Disorder(s) or mental illness(s). The contractor may not impose any limitations or formulary coverage restrictions on this benefit.
Long-Acting Injectable	No prior authorization Appendix F	The Contractor shall not require prior authorization of typical long-acting antipsychotics (e.g., haloperidol decanoate and fluphenazine decanoate).

[1] OMH has issued guidance to MMCPs which further outlines requirements related to prior authorization. Please note this guidance includes a requirement prohibiting prior authorization for pre-admission screening in OMH Part 512 PROS programs