Medicaid Advantage Plus (MAP) Plan and Provider Billing Webinar Frequently Asked Questions (FAQs)

July 20, 2022 MAP Billing Webinar for MAP Plans

#	Question	Answer
1.	How will MAP Plan utilization review be similar to the Health and Recovery Plan (HARP) product line? Will the behavioral health (BH) triggers outlined in the Best Practices Manual apply to MAP?	As with Mainstream and HARP Plans, MAP Plans must submit mental health clinical review criteria and associated policies and procedures for the Office of Mental Health (OMH) review and approval, subject to Chapter 57 of the Laws of 2019. MAP Plans are subject to Article 49 of the Public Health Law. Therefore, the statute requiring use of the Level of Care for Alcohol and Drug Treatment Referral (LOCADTR) for Office of Addiction Services and Supports (OASAS) services is applicable to MAP Plans. Please view the webinar held on July 6, 2022 for more information: https://www.ctacny.org/trainings/behavioral-health-carve-in-to-medicaid-advantage-plus-map-medical-necessity-criteria-review-for-map-plans/ The State's criteria for approval can be found in the OMH Guiding Principles and Best Practices Manual for Utilization Review for Adult and Child Mental Health Services. Level of care tools and policies and procedures that comply with the OMH Guiding Principles and utilize a targeted utilization management (UM) approach may be approved for use following OMH review.
2.	When does the government rate reimbursement floor mandate end?	The government rate mandate ends in 2027, pending further extension.
3.	Are rate codes only required for services covered by Medicaid? Are there any exceptions?	Rate codes are only required for Medicaid services, including services that are covered under both Medicaid and Medicare. Rate codes will also be required to be reported in the encounter data submitted to the State.

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4.	If a provider is not Medicare eligible due to licensure type (eg: LMFT), should they then process under Medicaid?	Correct. MAP Plans should reimburse the provider according to the Medicaid rate and report that as the Medicaid reimbursed amount on the encounter report. Please refer to the MAP BH Billing and Coding Manual (Page 3) for more information and the MAP Plan Billing Webinar slide 33 which outlines this scenario.
5.	What happens if an allowable provider type (e.g., MD) is not Medicare licensed? Would they default to the Medicaid portion?	If a professional type is Medicare enrollable, they should enroll and follow applicable MAP BH billing requirements.
6.	The New York State (NYS) MAP Plans Behavioral Health Billing and Coding Manual July 1, 2022, identifies Fee-for-Service (FFS) - Covered OMH/OASAS Services. Can you please clarify what services are under "Crisis Intervention Services for Youth ages 18-20"? Do these include CPEP and Crisis Residence? When Crisis Stabilization Centers go live, will these services be a benefit for members in MAP as well?	The MAP Plan benefit package will include the following crisis services: • CPEP (18+) • Mobile Crisis Services (authorized in the 1115 Waiver for adults 21+) • Crisis Residence Services (authorized in the 1115 Waiver for adults 21+). The Children and Family Treatment and Support Services (CFTSS) benefit includes Crisis Intervention services, both mobile crisis and crisis residences, for individuals under 21 years old. Medicaid FFS will reimburse for these two crisis services accessed by MAP enrollees aged 18-20. MAP Plans will be required to reimburse for CPEP services used by any MAP enrollees aged 18 and above. NYS submitted a State Plan Amendment (SPA) to the Centers for Medicare & Medicaid Services (CMS) in June 2022, which would authorize Medicaid reimbursement for Crisis Stabilization Centers. At first, Medicaid coverage of Crisis Stabilization Centers will be available through FFS. Once there are Crisis Stabilization Center providers licensed throughout the State, Crisis Stabilization Center services will be carved into the Medicaid Managed Care benefit packages for Mainstream, HARP, HIV-Special Needs Plans (HIV-SNP), and MAP Plans. NYS will issue guidance and provide ample

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		notice before MAP Plans will be required to cover Crisis Stabilization Center services. In addition to obtaining authorization for Crisis Stabilization Centers through the Medicaid State Plan, the amendment mentioned above also requests a streamlined, single Medicaid authority for mobile, residential and stabilization crisis services for all age ranges. If approved, and pending future guidance, billing and reimbursement requirements for crisis services to individuals ages 18-20 will be aligned with the crisis services for individuals 21+. The State will provide ample notice to MAP Plans prior to this change being effective.
7.	Is it possible there may be multiple Recipient Restriction Exception (RRE) codes, including H codes, for individuals enrolling into a MAP Plan? If so, which ones indicate Community Oriented Recovery and Empowerment (CORE) services eligibility?	An individual may have multiple RRE codes on their file. Only MAP enrollees with an H9 are eligible to receive CORE Services.
8.	Are Health Homes included within the MAP benefit package? Are Plans responsible for Health Home payments for MAP?	Health Homes, including Health Home Plus (HH+), are Medicaid covered services for MAP Plan members; however, they are not carved into the MAP benefit package and these services are billed through fee-for-service (FFS) for eligible MAP members. MAP Plans are not responsible for payment. The MAP Plan should have an Administrative Service Agreement in place with the Health Home per guidance issued 02/2016 (Guidance for Providing Care Coordination and Management to Medicaid Members Enrolled in MLTC Plans and Health Homes (ny.gov)). The MAP Plan will be the primary Care Management entity and collaborate with the member's Health Home.

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9.	Will the Medicaid Advantage Plus Operating Report (MAPOR) be amended to capture additional service categories for MAP?	The State is currently working on updates to the MAPOR to add additional categories for MAP. Additional information is forthcoming.
10.	Should the Department of Health (DOH) model notices be utilized for the authorization/denial letters?	Yes, DOH model notices should be utilized for the authorization denial letters.
11.	Will there be any changes to how MAP Plans bill DOH (different rate code, etc.) for membership pools of members receiving Medicaid BH services?	No, there are no tiered levels. The capitation rate for BH members of a MAP Plan will be paid to the MAP Plan under the same rate codes they currently use: 2374 and 2375. Capitation rates will be updated for MAP Plans to include BH Carve-in services for January 1, 2023. Any questions about BH Carve-in to MAP service rate setting should be sent to mltcrs@health.ny.gov.
12.	How will capitation rates reflect changes in mandatory reimbursement policy?	The updated capitation will reflect the mandate to pay government rates for services outlined in MAP BH Billing and Coding Manual.
13.	Will LOCADTR also remain in place during the transition?	Yes, LOCADTR remains in place during the transition.

July 27, 2022 MAP Billing Webinar for Providers

#	Question	Answer
1.	What are the new requirements for Article 31 clinics to bill MAP Plans on institutional claim forms?	The MAP Plan must be able to accept the institutional claim form and the provider must use the institutional claim form for all BH services so the rate code can be captured and reported by the MAP Plan and to facilitate payment of the "government rate" where applicable. It is the State's understanding that MAP Plans have an integrated billing system to process Medicaid and Medicare claims. Therefore, the provider would only need to submit one claim with all the relevant Medicaid and Medicare information as outlined in the MAP BH Billing and Coding Manual.
2.	Are there any changes to Home and Community Based Service (HCBS)/ Community Oriented Recovery and Empowerment (CORE) with MAP Plans?	At this time, the CORE Benefit and Billing Guidance is considered final and will apply to MAP Plans effective January 1, 2023. Adult BH HCBS are not carving into MAP.
3.	Is the billing manual released July 1, 2022 considered final for MAP?	At this time, the MAP BH Billing and Coding Manual released on July 1, 2022 is considered final. The State will issue updates if there are any policy changes going forward and will provide notice to Plans.
4.	Is a provider automatically credentialed for the MAP Plan if they are credentialed for a different product line from the same Managed Care Organization (MCO)?	The State recommends the provider to follow-up with the Plan to confirm credentialing for the MAP product line. MAP Plans are required to accept the 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. For additional details please see page 3 of the Behavioral Health MAP Guidance.

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5.	If Assertive Community Treatment (ACT) is carved into MAP Plans, how should a provider bill when the billing provider is Medicare-enrollable, but the services were delivered by non-Medicare-enrollable providers?	In traditional Medicare, the ACT program is not recognized. As a result, the status of the Medicare enrollable provider is not relevant. When ACT is carved-in, providers should follow the Medicaid rules for billing ACT. ACT Claiming Scenario (*Not actual rates, see Medicaid Reimbursement Page for actual rates*): ***Provider Type (Program Type): ACT*** ***Practitioner Type**: **Any practitioner type that is acceptable per ACT provider manual (Medicare enrollable or not)*** ***Service/procedure delivered**: ACT Full Intensive Full Payment* ***Medicaid Rate**: $100* ***Medicare Rate**: $0* **Provider should bill:** 1. Rate code: 4508 2. Procedure code: H0040 Please reference MAP Coding Taxonomy for BH services for applicable modifier(s). **MAP Plan should:** 1. Pay provider $100, e.g., Medicaid Rate 2. Report $0 for Medicare reimbursement amount and $100 for Medicaid reimbursement amount in encounter reporting to State
6.	Will the same revenue codes that are currently used for Medicaid Managed Care be used for MAP billing?	Yes, the same revenue codes will be used for Mainstream Medicaid Managed Care and the MAP product line.

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7.	Do current MAP members have H9 on their ePACES file if they are HARP eligible (i.e., current receiving CORE services)?	Prior to the MAP BH carve-in, some MAP enrollees may have an H9 on their file if they met the BH high-risk algorithm while previously enrolled in a Mainstream plan, HARP, or HIV-SNP. The H9 stayed on their file when they moved into a MAP Plan. As of August 2022, the BH high-risk algorithm is not being run for current MAP enrollees and NYS has not started adding H9s to MAP enrollee files. NYS expects to begin identifying MAP enrollees meeting the BH high-risk algorithm and adding H9s to their files in late 2022.
8.	Will there be training to assist providers in educating clients on the MAP Plans? Is there a resource for this process?	MAP Plans are required to offer information and training to their provider network on the MAP product line and benefits. The State encourages providers to reach out to their contracted MAP Plans regarding available education and resources. Providers can also access trainings and webinars conducted by the Managed Care Technical Assistance Center (MCTAC) related to BH services in managed care. See link: CTACNY
9.	If a claim is billed under the agency, not the individual, as the provider how should an Article 31 clinic fill in the “Attending” and “Referring” provider fields?	For these fields, the provider will bill the same way as is done for the Mainstream and HARP product line. The attending and referring fields are required to be completed for the claim to be processed. Please refer to the following link: NPI Attending Referring Guidance
10.	Will each County be required to offer one of the listed plans?	MCOs are not required to operate in all counties but rather they apply for the counties they wish to operate in for approval by the DOH. Please refer to the following link for information on MCOs and their approved counties for MAP: DOH MLTC Directory by County.
11.	Will MAP Plans’ premium be adjusted to reflect the BH services that will be carved in instead of a pass-through payment from State (aka 837)?	Yes. The premium will be adjusted to reflect BH services that will be carved in, and the MAP Plans will pay for BH services out of their premiums.
12.	For Personalized Recovery Oriented Services (PROS) clinic services, if all the clinic treatment	If all the services delivered were provided by non-Medicare enrollable clinicians/practitioners, the provider would bill the rate

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	services were provided by non-Medicare-enrollable clinicians, should the provider bill for each service or just the single T1015 code?	code 4525 and the procedure code T1015. Please refer to the coding taxonomy: MAP Coding Taxonomy for BH services
13.	Why are there Medicare rates for services covered by Medicaid (eg. in the Scenarios provided, PROS had Medicaid and Medicare rates)? Do MCOs have to determine the higher rate?	Procedure codes (CPT and HCPCs) are used for both Medicaid and Medicare billing, and the "higher of" provision applies to services covered under both Medicaid and Medicare. As Medicaid is the payor of the last resort, Medicare would need to cover the initial payment before Medicaid kicks in. MCOs will be responsible for determining payment responsibilities based on claims submitted.
14.	What is the percentage of Medicare/Medicaid covered individuals already enrolled in MAP Plans in NYS? Will there be a mandate for them to enroll into a MAP Plan?	As of August 2022, there are 34,355 individuals enrolled in MAP Plans. MAP is a voluntary program and individuals are not mandated to enroll.
15.	Does a provider need to apply to be in-network to serve members who are enrolled in MAP Plans?	The State encourages providers to work with MAP Plans to enter into contracts for members the Agency is serving, however a provider does not need to be in-network to serve the member as the MAP Plan can enter into a single case agreement with the Agency. Per the Behavioral Health MAP Guidance, MAP Plans are required to offer contract to providers to meet network adequacy requirements and adhere to the continuity of care provisions during the transition period.
16.	What are the UM and pre-authorization requirements for MAP Plans?	Per the Behavioral Health MAP Guidance: *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.* I. *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.*

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		II. *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.* Please note: MAP Plans cannot conduct UM for CORE Services until notified by NYS. This notification will occur with adequate time to operationalize any CORE UM standards.
17.	Should providers still bill other Medicare Advantage claims on professional claim forms?	MAP enrollees are in an integrated product that consists of a Medicare Advantage Plan and a Medicaid plan operated by the same corporation. As a result, the provider would only need to submit one claim on the institutional form for BH services. For the scenario where the provider needs to bill a Medicare Advantage Plan that is unrelated to (not affiliated with) Medicaid plan, MAP billing requirements would not be applicable, and the provider should follow appropriate procedures for crossing over the claim to Medicaid after billing Medicare.
18.	How will MAP codes on ePACES work? How can a provider identify clients enrolled in a MAP Plan?	Providers should utilize ePACES to identify/verify MAP member eligibility and enrollment. In ePACES providers can check the Plan code to identify which MAP Plan the member is enrolled in. Link to MAP plan codes can be found here: INFORMATION FOR ALL PROVIDERS MANAGED CARE INFORMATION (emedny.org) Providers can also check the Medicaid Exception section to see if the member has an H9 to confirm eligibility for CORE services.
19.	Who is the primary payor for Partial Hospitalization under MAP Plans after January 1, 2023?	Per the Medicaid Advantage Plus (MAP) Model Contract (Appendix K3, page 190), prior to January 1, 2023 MAP Plans are not responsible for the provision and payment of Partial Hospitalization and is reimbursed through Medicaid fee-for-service. Beginning January 1, 2023 and going forward Partial Hospitalization will be carved-in and will be reimbursable through Medicaid.

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20.	When billing MAP Plans, should providers use the Medicaid ID or the insurance plan ID for claim submission?	The State advises providers to include both the Member ID and Insurance ID, fields 3a and 60a, respectively. Please refer to the MCTAC UB-04 Billing Tool for more information.
21.	Have the MAP Plans been asked to validate their system capability to default to the higher of the two rates, Medicare vs. Medicaid, when applicable?	Yes, the MAP Plans are aware of the billing requirements and attesting to meeting all requirements. The State encourages all BH providers to claims test with their contracted MAP Plans to ensure claims are processing accurately. This will be especially important for providers who deliver BH services which are covered both under Medicaid and Medicare to ensure the provider is receiving the higher of rate.
22.	Will there be any need for crossover claims?	No, the provider will not need to crossover claims submitted to MAP Plans. It is the State's understanding that MAP Plans have an integrated billing system to process Medicaid and Medicare claims. Therefore, the provider would only need to submit one claim with all the relevant Medicaid and Medicare information as outlined in the MAP Billing Guidance.
23.	In PROS a different CPT code is used for services provided by clinicians who can and can't be enrolled in Medicare, but in clinic is the same CPT code used for Medicaid-enrollable and non-Medicaid-enrollable provider types?	The procedure codes used to bill Medicare for clinic (not in PROS) are not different than what are used for Medicaid (e.g. Mainstream/HARP). However, in a PROS clinic, the Medicaid required procedure code and reimbursement structure is different than Medicare. After January 1, 2023, since MAP has an integrated system, the provider will only need to submit one claim with all applicable Medicare and Medicaid procedure codes listed during the month services were delivered by all Medicare enrollable and/or non-Medicare enrollable practitioner(s).
24.	Is there any difference in the reimbursement requirements for Federally Qualified Health Center (FQHC) programs opted out of Ambulatory Patient Groups (APG) and paid at Prospective Payment Systems (PPS) rates?	FQHCs are also entitled to the government rate (their Medicaid FFS rate) when they provide BH outpatient services, which may be the PPS rate or the APG rate depending on what the FQHC is using to be reimbursed in Medicaid. Link to more information: FQHC Medicaid Reimbursement Option

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25.	Are clinicians not enrolled in Medicare (LMSW, LMHC, LMFT) allowed to see MAP clients as long as they are supervised by a Medicare enrolled clinician (LCSW)?	This depends on the service being delivered. Please see link to the 599 regulations (see page 60) which provides details on staffing flexibility for mental health services.
26.	Since there will be no crossover billing will the electronic 837 file separate Medicare and Medicaid reimbursements?	No, the MAP Plans will be responsible for splitting Medicare and Medicaid payment on the backend based on information included on the claim, and report these amounts respectively on the encounter data.
27.	Do MAP Plans cover the after-hours add on and the Language Other than English add-on?	Yes, the add-ons for after-hours and Language Other than English are covered in the APG rate and should be paid by MAP Plans when billed appropriately.
28.	If a provider is out-of-network with a MAP Plan, is the MAP Plan still mandated to pay the provider at the government rate for Medicaid BH services?	MAP Plans must reimburse non-participating providers at least 100% the government rate for the following services/scenarios: 1. Emergency (crisis intervention/CPEP) 2. Continuity of care provisions 3. Single case agreement 4. The MCO does not have a Participating Provider with appropriate training and experience to meet the particular health or behavioral health care needs of an Enrollee, or the participating provider does not have an available appointment. The government rate reimbursement floor is mandated until March 31, 2027, pending further extension.
29.	Are there any trainings, including coding, for Medicare Advantage?	This FAQ is specific to Medicaid Advantage Plus. For Medicare Advantage, the provider is encouraged to work with their Medicare Advantage Plans for trainings and technical assistance on billing and coding.

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30.	Will individuals eligible for these MAP Plans be auto-enrolled beginning in January?	No.
31.	Are individuals in these plans eligible for Health Home Care Management?	Yes. The MAP Plan should have an Administrative Service Agreement in place with the Health Home per guidance issued 02/2016 (attached and located at Guidance for Providing Care Coordination and Management to Medicaid Members Enrolled in MLTC Plans and Health Homes (ny.gov). The MAP Plan will be the primary Care Management entity and collaborate with the member's Health Home.
32.	What is the difference between PACE, Medicaid Advantage, Medicaid Advantage Plus, and/or the Partial Capitation Managed Long Term Care (MLTC) plans?	Medicaid Advantage sunsetted on December 31, 2021. Information on the distinction between PACE, Medicaid Advantage Plus, and/or the Partial Capitation, can be found here Managed Long Term Care (MLTC) (ny.gov), along with an updated 2022 Consumer Guide.
33.	Can a client apply for a MAP Plan if they are not Medicaid-eligible due to income?	No, the MAP Plan is only for people eligible for Medicaid and Medicare.
34.	Is PACE part of the MAP transition?	No, PACE is a separate product line and Plan type. See link for information: About Managed Long Term Care (ny.gov)
35.	Currently outpatient substance use disorder (SUD) providers not contracted with Medicare are only paid out-of-network benefits by Medicare Advantage plans. Medicaid and/or MCOs do not pay the difference. Will this change under MAP Plans?	MAP Plan will have to contract according to the MAP Model Contract, Behavioral Health MAP Guidance, and the MAP Billing and Coding Manual. The State encourages providers to work with MAP Plans to enter into contracts for members the Agency is serving, however a provider does not need to be in-network to serve the member as the MAP Plan can enter into a single case agreement with the Agency.
36.	Will OASAS providers that did not need to acquire a Medicare provider number now need to apply to Medicare in order to bill MAP Plans?	Providers are required to enroll with Medicare to bill MAP Plans. Please see these links for more information: • Letter to OTPs (cms.gov) • OTP Enrollment