NEW YORK REQUEST FOR QUALIFICATIONS FOR BEHAVIORAL HEALTH BENEFIT ADMINISTRATION:

Managed Care Organizations and Health and Recovery Plans

December 5, 2013 Draft For Public Review

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1.0 Background

1.1 Vision

New York seeks to create an environment where managed care plans, service providers, peers, families, and government partner to help members prevent chronic health conditions and recover from serious mental illness and substance use disorders. The partnership will be based on the following values:

1. *Person-Centered:* Care should be self-directed whenever possible and emphasize shared decision-making approaches that empower members, provide choice, and minimize stigma. Services should be designed to optimally treat illness and emphasize wellness and attention to the entirety of the person.

2. *Recovery-Oriented:* The system should include a broad range of services that support recovery from mental illness and/or substance use disorders. These services support the acquisition of living, vocational, and social skills, and are offered in settings that promote hope and encourage each member to establish an individual path towards recovery.

3. *Integrated*: Service providers should attend to both physical and behavioral health needs of members, and actively communicate with care coordinators and other providers to ensure health and wellness goals are met. Care coordination activities should be the foundation for care plans, along with efforts to foster individual responsibility for health awareness.

4. *Data-Driven*: Providers and plans should use data to define outcomes, monitor performance, and promote health and wellbeing. Plans should use service use data to identify high-risk/high-need members in need of focused care management. Performance metrics should reflect a broad range of health and recovery indicators beyond those related to acute care.

5. *Evidence-Based*: The system should incentivize provider use of evidence-based practices (EBPs) and provide or enable continuing education activities to promote uptake of these practices.[1] NYS intends to partner with plans to educate and incentivize network providers to deliver EBPs. The NYS Office of Mental Health will provide technical assistance through the Center for Practice Innovations at Columbia University/New York State Psychiatric Institute as well as the Clinic Technical Assistance Center at New York University.

1.2 The Current System of Care

The Mental Health System: The past 30 years have seen a transformation of the public mental health system. The State operated adult psychiatric hospital census has declined from over 20,000 to under 2,900. Access to outpatient treatment, community supports, rehabilitation, and general hospital psychiatric inpatient services have dramatically expanded. More than 38,000 units of state supported community housing for people living with mental illness have been developed. These community based resources have created a

[1] For review of EBPs for individuals with serious mental illness see: Dixon LD, Schwarz EC: Fifty years of progress in community mental health in US: the growth of evidence-based practices. *Epidemiology and Psychiatric Sciences,* published on-line November 12, 2013, DOI: 10.1017/S2045796013000620

safety net which has helped the mental health system to evolve from a primarily hospital focused system to one of community support. The emergence of the peer recovery and empowerment movement in the 1990s has stimulated the shift in focus from support to recovery. The legal system's expansion of civil rights to include people with mental illness, as part of Olmstead Legislation, has begun to move policy from the concept of least restrictive setting to full community inclusion.

As a result of the growth in community services, OMH now funds and licenses more than 2,500 mental health programs serving 700,000 people annually. These programs are operated by the State, local governments, not-for profit agencies and for profit organizations. They provide outpatient and inpatient treatment, rehabilitation, emergency services, housing, community support and vocational services. The majority of services are delivered to individuals with a serious mental illness (SMI) or children and adolescents who have a serious emotional disturbance (SED). These individuals suffer from the most difficult and complex mental health conditions and often have co-morbid physical health and substance use ailments.

Funding for the system's array of services is a complex mix of Medicaid, State aid, county support, other funding, and private insurance. The Medicaid program is the State's largest payer for mental health services, and accounts for 48% of the public mental health system. Inpatient psychiatric services in discrete psychiatric units of general hospitals, private psychiatric hospitals and OMH-operated psychiatric centers represent $3.67 billion of total mental health spending.

As a result of history, population, funding, and local priorities, the structure and content of mental health services vary considerably by region and county. For a more complete overview of the New York Mental Health System, follow the links to OMH documents:

1. 2012 OMH 5.07 Plan
2. OMH planning Website
3. OMH Statistics and Reports

The Substance Use System: OASAS plans, develops and regulates the State's system of substance use disorder and gambling treatment agencies. This includes the direct operation of 12 Addiction Treatment Centers, which provide inpatient rehabilitation services to approximately 10,000 persons per year. In addition, the Office licenses, funds, and supervises nearly 1000 community-based substance use disorder treatment programs, which serve about 100,000 persons on any given day and 245,000 unique individuals annually in a wide range of comprehensive services. The agency inspects and monitors these programs to guarantee quality of care and to ensure compliance with State and national standards.

Substance Use Disorders are chronic health conditions that often co-occur with associated mental health and physical health problems. Treatment is focused on life-long recovery and disease management skills including management of co-occurring disorders and a holistic plan for regaining health. Peer support, housing, family, social and spiritual supports are integral to successful treatment. Patients should receive care that is evidence-based including addiction and/or psychotropic medications when indicated by their history and symptoms.

Too many patients with SUD are re-admitted to crisis or inpatient services within a 12 month period because they were not connected to effective community based clinical and recovery services. In 2011, 91,734 people were admitted to a crisis level of service and 39,126 were admitted to an inpatient program. Of the 130,860 inpatient and detox admissions in CY 2011, 16,027 (12.3%) were linked to a community service within 14 days of discharge and 57,717 (44.1%) were readmitted to an inpatient or detox within 12 months. We need to build care coordination and recovery supports in the community to reduce unnecessary readmissions and improve outcomes for patients in SUD treatment.

For a more complete overview of the New York Substance Use Disorder System, follow the link to OASAS Planning Documents: http://www.oasas.ny.gov/hps/state/state.cfm

1.3 Medicaid Redesign: Many Challenges Remain

While much progress has been made, achieving NY's vision for improved health (BH/PH), recovery, and community integration requires that public policy continue to be redesigned and resources reallocated. For many adults with serious mental illness and substance use disorder, the broad array of treatment options is difficult to navigate. The current service system does not always ensure priority access to individuals with the highest needs. Services provided by different clinicians are not always well-coordinated, and payments for services provided are not always structured to provide incentives that promote recovery.

Data collected through New York State's BHO 1 initiative shows that despite the efforts of many committed professionals, the connectivity from inpatient psychiatric care and/or inpatient detoxification to outpatient care – both behavioral health and physical health – remains low and hospital readmission rates remain high[2]. Medicaid's behavioral health resources are still largely unmanaged and services are paid through a fee for service model which lacks accountability for outcomes and leads to fragmentation of care. A listing of system problems illustrates this.

i. Twenty percent of people discharged from general hospital psychiatric units are readmitted within 30 days. A majority of these readmissions are to a different hospital.
ii. Discharge planning often lacks strong connectivity to outpatient aftercare and there is a lack of assertive engagement and accountability in ambulatory care. This weak accountability and proactive engagement contributes to readmissions, overuse of emergency rooms, poor outcomes, and public safety concerns.
iii. There is a lack of care coordination for people with serious SUD problems which leads to poor linkage to care following a crisis or inpatient treatment.
iv. A significant percentage of the homeless singles population has serious mental illness and/or substance use disorder.
v. People with mental illness and/or substance use disorders are over represented in jails. For example, approximately 42% of individuals in NYC jails have a primary substance use disorder and 33% have a mental health diagnosis. Of those with a mental health diagnosis, about 50% have a co-occurring substance use disorder diagnosis.

[2] See http://www.health.ny.gov/health_care/medicaid/redesign/docs/2013-05-01_mrt_bh1_slides_resubmitted_5-7.pdf

vi. The unemployment rate for people with serious mental illness is 85%.

vii. 33% percent of people entering detox were homeless and 66% were unemployed in 2011.

viii. People with serious mental illness die about 25 years sooner than the general population, mainly from preventable chronic health conditions.

ix. People with serious mental illness and/ or substance use disorder frequently have poor access to primary care due to stigma and other factors.

x. Poor management of medication and pharmacy contributes to inappropriate poly-pharmacy, inadequate medication trials, inappropriate formulary rules, poor monitoring of metabolic and other side effects, and lack of a person centered approach to medication choices. In SUD treatment, patients often lack access to appropriate medications due to lack of management and inadequate number of certified physicians or programs that provide medication services.

Governor Cuomo, recognizing these problems, has called for "a fundamental restructuring of (the) Medicaid program to achieve measurable improvement in health outcomes, sustainable cost control, and a more efficient administrative structure". The Governor appointed a broadly representative Medicaid Redesign Team (MRT) to review and provide recommendations to achieve these objectives.

An MRT Behavioral Health (BH) work group was created in 2011 to guide the restructuring of behavioral health Medicaid services. This work group was co-chaired by Linda Gibbs, the Deputy Mayor of New York City and Michael Hogan, then Commissioner of the Office of Mental Health (OMH). The 22 members of the work group included Commissioner Arlene González Sánchez of the Office of Alcoholism and Substance Abuse Services (OASAS), advocates, providers, insurers, and other stakeholders from the New York behavioral health community.

The work group produced a series of recommendations concerning BH system transformation. These recommendations served as a guide in the design of this managed care initiative[3].

1.4 Legal Authority

Section 365-m of the NYS Social Services Law authorizes the commissioners of the Office of Mental Health, the Office of Alcoholism and Substance Abuse Services and the Department of Health, in consultation with the local social services district and local governmental unit (LGU), to designate a sufficient number of managed care plans capable of managing the behavioral health needs of individuals enrolled in Medicaid managed care to manage, coordinate and pay for the behavioral health services for such enrollees. In regions with sufficient populations, the Commissioners, in consultation with the local social services district and local governmental unit, are authorized to designate special needs managed care plans to managed, coordinate and pay for the behavioral health and physical health needs of managed care enrollees with significant behavioral health needs.

[3] See http://www.health.ny.gov/health_care/medicaid/redesign/docs/mrt_behavioral_health_reform_recommend.pdf

1.5 Program Design

A. New York is taking a multi-pronged approach to the incorporation of behavioral health services in managed care. This approach is as follows:

i. **Mainstream MCOs**: For all adults served in mainstream MCOs throughout the State, the qualified MCO will integrate all Medicaid State Plan covered services for mental illness, substance use disorders (SUDs), and physical health (PH) conditions. Plans must meet the criteria contained in this RFQ to qualify to administer the BH benefit. Premiums for mainstream Plans will be adjusted to reflect the additional BH benefits of mainstream enrollees.

ii. **Health and Recovery Plans** (HARPs): HARPs are a distinctly qualified, specialized and integrated managed care product for adults meeting the serious mental illness (SMI) and SUD targeting criteria and risk factors (see page 10).

Within the HARPs, an enhanced benefit package will be offered in addition to all Medicaid behavioral health and physical health benefits. The enhanced array of home and community services are for HARP enrolled individuals who meet both targeting and risk factors, as well as needs-based criteria for functional limitations (see page 11). The enhanced benefit package will help maintain participants in home and community based settings.

The qualified HARP, contracting with Health Homes, will provide care coordination for all services including the 1915(i)-like Home and Community Based Services in compliance with home and community-based standards and assurances.

HARPs will have an integrated premium established for this behavioral health population. They will have specialized staffing requirements and qualifications along with focused behavioral health performance metrics and incentives to achieve health, wellness, recovery, and community inclusion for their members.

iii. **Children in Mainstream MCOs**: Children's specialty BH services, including all four BH HCBS waivers operated by OMH and the Office of Children and Family Services, will be included in the mainstream MCOs at a later date. Plans will need to meet additional standards and contract requirements for the management of children's services at that time. Plans will participate in a readiness review to ensure that they meet all the requirements to manage the full scope of the children's service system of care.

iv. **Integration of State Operated Psychiatric Services:** OMH is making several changes to the State operated psychiatric system as part of the creation of Regional Centers of Excellence (RCEs). The RCE plan includes the establishment of fifteen Regional Centers of Excellence across the State along with a network of state-operated community-based services that will respond to local needs. The consolidation of State operated psychiatric hospitals will result in approximately 600 fewer adult state psychiatric beds. As many of the individuals using these beds will be enrolled in managed care, MCOs will be responsible for participating in discharge planning for their members and providing access to and overseeing aftercare services.

Medicaid will continue to exclude reimbursement for inpatient care for persons aged 21-64 in Institutions for Mental Diseases, both public and private. This means that MCOs are not financially responsible for their enrollees who are admitted to or transferred to OMH psychiatric centers. OMH envisions a consumer-oriented model where Plans will be responsible for managing admissions and discharges from State hospitals, in addition to providing assistance in moving long stays out of State operated facilities. To begin this process, OMH is identifying historic and current admissions and lengths of stay at OMH inpatient facilities for adults enrolled in Medicaid Managed Care. As the RCE restructuring stabilizes, OMH and DOH will work with the MCOs to make the plans accountable financially for continuing admissions/transfers of their members to the State facilities.

1.6 Purpose of the Request for Qualifications (RFQ)

A. The movement of the Medicaid behavioral health funding to managed care presents both challenges and opportunities. Carving behavioral health into mainstream Plans offers the opportunity to address the full range of health care needs. The integrated health premium will allow Plans to more effectively help members manage their behavioral and physical health needs in an integrated manner. Additionally, a managed system can purposefully reinvest savings from a decrease in unnecessary and expensive hospital stays into recovery services and housing rehabilitation supports.

   However, Medicaid Managed Care Plans in NYS today only manage a limited range of behavioral health services. Many Plans do not have experience with the higher needs populations that will be coming into care management or the broader array of services that are needed to support functioning in the community, often over long periods of time.

   Plans must therefore submit applications to New York State demonstrating that they have the organizational capacity and culture to ensure the delivery of effective behavioral health care and facilitate system transformation. These applications will be reviewed against new behavioral health specific administrative, clinical, program, and fiscal standards.

   Because Plans may not have the expertise to manage specialty BH benefits, they may need to partner with experienced vendors or providers or subcontract with a BH organization that meets the qualifications.

B. The purpose of this RFQ is to qualify:

   i. Current mainstream Medicaid MCOs in NYS to administer the full continuum of MH, SUD, and PH services covered under the Medicaid State Plan for adults who do not meet HARP eligibility criteria or who qualify but choose not to enroll; and

   ii. Current mainstream Medicaid MCOs seeking to become HARPs in NYS to administer the full continuum of MH, SUD, and PH services covered under the Medicaid State Plan as well as the enhanced HCBS benefit package (1915(i)-like rehabilitation and recovery services) for adults with serious mental illness (SMI) and/or SUDs who meet HARP targeting and risk factors and/or 1915(i)-like functional eligibility criteria defined in 1.8, Article B through D of the RFQ.

C. NYS will qualify MCOs and HARPs to serve adults in 2 rounds based on geographic region and population characteristics. The first round will be in New York City (NYC). The second

round will be for the rest of the state (ROS). Additionally, New York will amend Managed Care contracts at a later date to incorporate specialty BH benefits for children.

D. Integration of all Medicaid BH and PH benefits under managed care will take place as follows:
   i. Adults in New York City on January 1, 2015
   ii. Adults in the rest of the State on July 1, 2015
   iii. Children statewide on January 1, 2016.

1.7 System Goals, Operating Principles, Requirements and Outcomes

A. **Goals**: The qualification process for MCOs and HARPs is necessary to ensure each has adequate capacity to assist NYS in achieving system reform goals including:
   i. Improved health outcomes and reduced health care costs through the use of managed care strategies and technologies including, but not limited to BH-specific protocols for:
      a. Member services (intake, referral, crisis response)
      b. Utilization management;
      c. Medical management;
      d. Network management;
      e. Quality management;
      f. Data management; and
      g. Reporting and financial management.
   ii. Transformation of the BH system from an inpatient focused system to a recovery focused outpatient system of care.
   iii. Improved access to a more comprehensive array of community-based services that are grounded in recovery principles including:
      a. Person centered care management;
      b. Patient/consumer choice;
      c. Member and family member involvement at all system levels; and
      d. Full community inclusion.
   iv. Integration of physical and behavioral health services and care coordination through program innovations that address workforce development; risk screening; data integration and data analytics; and specialized case management and care coordination protocols.
   v. Effective innovation through the use of evidence-based practices.
   vi. Improved cross system collaboration with State and local resources, including State and locally funded MH and SUD services, housing subsidies and supports, the judicial system, welfare programs, and other local resources necessary to promote recovery outcomes.
   vii. Delivery of culturally competent services.
   viii. Assurance of adequate and comprehensive networks with timely access to appropriate services.

ix. Continuity of care from fee-for-service (FFS) to managed care.

B. **Principles/Requirements**: These goals will be realized in both new and existing programs through the application of the following:

i. Earlier identification and intervention through the use of validated screening tools where available for common conditions such as anxiety, depression, and alcohol misuse.

ii. Person-centered treatment that integrates attention to behavioral and physical health care and to social needs within a framework that is strengths-based; culturally relevant; incorporates natural supports; and promotes hope, empowerment, mutual respect, and full community inclusion.

iii. Use of integrated care models such as the Collaborative Care model for treating BH conditions in primary care.

iv. An inclusive provider network that contains a wide range of providers with expertise in treating and managing SMI and SUD consumers including community based providers of behavioral health and substance use services and peer delivered services.

v. Efficient and timely service delivery, care coordination, and care management with minimal duplication across providers and between providers and the Plan.

vi. Access to care management and clinical management from a Health Home or MCO as appropriate.

vii. Enhanced discharge planning and follow-up care between provider visits.

viii. Reliance on specialized expertise for the assessment, treatment, and management of special populations, including older adults, transition age youth, individuals with co-occurring disorders (e.g. high risk medical populations), individuals experiencing a first episode psychosis (FEP), individuals with SMI and criminal justice or assisted outpatient treatment (AOT) involvement, and individuals with SMI and/or functionally limiting SUDs.

ix. Service delivery within a comprehensive system of care, which emphasizes the most appropriate, least restrictive settings to promote and maintain the highest practical level of functioning.

x. Medical necessity determinations that consider level of need as well as environmental factors, available resources and psychosocial rehabilitation standards.

xi. For behavioral health, Level of Care and clinical guidelines approved by the State.

xii. For SUD, Level of Care determinations based on the OASAS LOCADTR tool.

xiii. Use of national data regarding evidence-based and promising practices as well as data from NYS regarding utilization and unmet needs to guide network enhancements and the allocation of resources to support individuals in achieving wellness and recovery.

xiv. Use of data-driven approaches to performance measurement, management, and improvement with regular reporting of results on key performance indicators to stakeholders (e.g., consumers, providers, other member serving systems).

xv. Heightened monitoring of the quality of behavioral health and medical care for all members (those with mild and moderate conditions and those with high BH needs) with the use of ongoing outcome measurements intended to raise expectations for improvement in access, utilization, care coordination, health and recovery outcomes.

xvi. Regular and ongoing technical support and training and workforce development with network BH and PH providers as well as managed care staff to achieve system transformation and to develop competency in current and emerging EBPs and other best practices.

xvii. Promotion of operational policies and procedures that support these principles across healthcare providers, managed care Plans and other State and local agencies.

xviii. Use of financial structures that support and/or incentivize achieving system goals.

xix. Separate tracking of BH expenditures and administrative costs to ensure adequate funding to support access to appropriate BH services.

xx. Medical Loss Ratio (MLR) for HARPs and BH MLR for Mainstream MCOs.

xxi. Reinvestment of behavioral health savings to improve services for behavioral health populations.

xxii. Enhanced pharmacy management for individuals with co-occurring complex MH and SUD challenges.

C. **Outcomes**: Achievement of system goals are expected to result in the following outcomes:

i. Improved individual health and behavioral health life outcomes;

ii. Improved social/recovery outcomes including employment;

iii. Improved member's experience of care;

iv. Reduced rates of unnecessary or inappropriate emergency room use;

v. Reduced need for repeated hospitalization and re-hospitalization;

vi. Reduction or elimination of duplicative health care services and associated costs; and

vii. Transformation to a more community-based, recovery-oriented, person-centered service system.

1.8 Covered Populations and Eligibility Criteria

This RFQ covers the inclusion of Medicaid BH services for adults in mainstream MCOs. Dual eligibles (persons who are both Medicaid and Medicare enrolled) are not included at this time but may be at a later date. Specific eligibility is as follows:

A. **Qualified Mainstream Managed Care Plans:** All mainstream Medicaid eligible and enrolled individuals 21 and over requiring behavioral health services.

B. **HARPS:** Adult Medicaid beneficiaries[4] who are eligible for mainstream MCOs are eligible for enrollment in the HARP if they meet either:

i. Target criteria and risk factors as defined below (Individuals meeting these criteria will be identified through quarterly Medicaid data reviews by Plans and/or NY State); or

ii. Service system or service provider identification of individuals presenting with serious functional deficits as determined by:

[4] One exception: individuals in nursing homes for long term care will not be eligible for enrollment in HARPS.

a. A case review of individual's usage history to determine if Target Criteria and Risk Factors are met; or

b. Completion of HARP eligibility screen.

C. **HARP Target Criteria:** The State of New York has chosen to define HARP targeting criteria as:

i. Medicaid enrolled individuals over 20 years of age (21 and over);

ii. SMI/SUD diagnoses;

iii. Eligible to be enrolled in Mainstream MCOs;

iv. Not Medicaid/Medicare enrolled ("duals");

v. Not participating or enrolled in a program with the Office for People with Developmental Disabilities (OPWDD) (i.e., participating in an OPWDD program).

D. **HARP Risk Factors**: For individuals meeting the targeting criteria, the HARP Risk Factor criteria include any of the following:

i. Supplemental Security Income (SSI) individuals who received an "organized"[5] MH service in the year prior to enrollment.

ii. Non-SSI individuals with three or more months of Assertive Community Treatment (ACT) or Targeted Case Management (TCM), Personalized Recovery Oriented Services (PROS) or prepaid mental health plan (PMHP) services in the year prior to enrollment.

iii. SSI and non-SSI individuals with more than 30 days of psychiatric inpatient services in the three years prior to enrollment.

iv. SSI and non-SSI individuals with 3 or more psychiatric inpatient admissions in the three years prior to enrollment.

v. SSI and non-SSI individuals discharged from OMH Psychiatric Center after an inpatient stay greater than 60 days in the year prior to enrollment.

vi. SSI and non-SSI individuals with a current or expired Assisted Outpatient Treatment (AOT) order in the five years prior to enrollment.

vii. SSI and non-SSI individuals discharged from correctional facilities with a history of inpatient or outpatient behavioral health treatment in the four years prior to enrollment.

viii. Residents in OMH funded housing for persons with serious mental illness in any of the three years prior to enrollment.

ix. Members with two or more services in an inpatient/outpatient chemical dependence detoxification program within the year prior to enrollment.

x. Members with one inpatient stay with a SUD primary diagnosis within the year prior to enrollment.

xi. Members with two or more inpatient hospital admissions with SUD primary diagnosis or members with an inpatient hospital admission for an SUD related medical

[5] An “organized” MH service is one which is licensed by the NYS Office of Mental Health.

diagnosis-related group and a secondary diagnosis of SUD within the year prior to enrollment.

xii. Members with two or more emergency department (ED) visits with primary substance use diagnosis or primary medical non-substance use that is related to a secondary substance use diagnosis within the year prior to enrollment.

xiii. Individuals transitioning with a history of involvement in children's services (e.g., RTF, HCBS, B2H waiver, RSSY).

E. **1915(i)-Like Service Eligibility and Assessment Process:** HARP members who meet Targeting Criteria and Risk Factors as well as Need-Based Criteria (below), will have access to an enhanced benefit package of 1915(i) like Home and Community-Based Services (HCBS).

i. **Need-based Criteria**: Individuals meeting one of the Needs-Based Criteria identified below will be eligible for 1915(i)-like services:

a. An individual with at least "moderate" levels of need as indicated by a State designated score on a tool derived from the interRAI Assessment Suite.

b. An individual with need for HCBS services as indicated by a face to face assessment with the interRAI Assessment Suite and a risk factor of a newly-emerged psychotic disorder suggestive of Schizophrenia herein called individuals with First Episode Psychosis (FEP). Individuals with FEP may have minimal service history.

c. A HARP enrolled individual who either previously met the needs-based criteria above or has one of the needs based historical risk factors identified above; AND who is assessed and found that, but for the provision of HCBS for stabilization and maintenance purposes, would decline to prior levels of need (i.e., subsequent medically necessary services and coordination of care for stabilization and maintenance is needed to prevent decline to previous needs-based functioning).

ii. All individuals in the HARP will be evaluated for eligibility for 1915(i)-like services.

a. Once an individual is enrolled in the HARP, a Health Home care manager (or other qualified individual) will initiate an independent person-centered planning process to determine a plan of care.

b. This will include the completion of an evaluation for 1915(i)-like eligibility.

c. This process will comply with federal conflict-free requirements.

iii. Individuals determined eligible for the 1915(i)-like services based on the brief evaluation will receive a conflict-free functional assessment from an appropriately qualified individual,

a. The assessment determines the medical and psychosocial necessity and level of need for specific HCBS services; ensures that inappropriate and unnecessary services are not provided; and is used to establish a written, person-centered, individualized plan of care.

b. Assessments are conducted using a standardized clinical and functional assessment tool consistent with the State's approved Balancing Incentive Payment Program[6].

iv. The results of the functional assessment will be incorporated into the individual's person-centered plan of care.

v. These plans must be approved by the HARP.

vi. The plan of care must be revised at least annually or sooner if needed.

1.9 HARP Enrollment

A. New York will phase-in enrollment to HARPs (i.e., New York City versus the rest of the state).

B. New York estimates that statewide there are initially 140,000 Medicaid Managed Care enrollees – 80,000 in New York City and 60,000 in the rest of the state - meeting targeting criteria and risk factors that will be enrolled in the HARPs.

C. Individuals will be identified as potentially needing HARP services on the basis of historical service use or completion of a HARP eligibility screen.

i. Initially, the State will provide rosters to MCOs of their members whose service use histories indicate a need for HARP.

D. Once a member is identified as HARP eligible, they can enroll in a HARP at any point.

E. A key goal in this managed care design is to avoid disrupting access to physical health care for individuals already enrolled in a mainstream Plan. Therefore, individuals initially identified as HARP eligible who are already enrolled in an MCO with a HARP will be passively enrolled in that Plan's HARP. This will ensure that Plan members will continue to have access to the same network of physical health services as the new BH benefits are brought into the Plan.

i. Plans with a HARP line of business will auto-enroll rostered individuals in their HARP.

ii. As part of the passive enrollment process, these individuals will be informed about HARP benefits as well as their ability to stay in their existing mainstream Plan or chose another HARP.

F. Individuals initially identified as HARP eligible who are already enrolled in an MCO **without** a HARP will be notified by their Plan of their HARP eligibility and referred to an enrollment broker to help them decide which Plan is right for them.

G. Members will be given 90 days to opt out of the HARP before they are locked into the HARP.

H. Once a member has enrolled in a HARP, they are locked into that Plan until the next open enrollment period.

I. Individuals initially identified as HARP eligible ***but not*** currently enrolled in managed care will be referred to enrollment broker to help them decide which Plan is right for them.

[6] See: http://www.health.ny.gov/health_care/medicaid/redesign/balancing_incentive_program.htm

J. New HARP enrollees will be required to be assigned to a Health Home with a designated care manager within 15 days of being enrolled in the HARP.

K. New York will provide guidance in the final RFQ regarding any potential changes in a HARP enrollee's status (e.g., diagnosis, service need) that indicate that the individual should transfer to a mainstream Plan.

1.10 Covered Services

A. The MCO and HARP contracts for enrolled beneficiaries will cover all current physical health services and pharmacy benefits covered under mainstream managed care.

B. The MCO and HARP contracts will cover Medicaid BH services including inpatient and outpatient hospital services and community-based rehabilitation and clinic services.

   i. Table 1 summarizes the core benefit package available to the adults enrolled in the MCO/HARP as of the start-up date.

C. HARP contracts will also cover the provision of 1915(i)-Like services.

   i. Table 2 summarizes the enhanced benefit package available as of the start-up date to Medicaid eligible adults meeting targeting, risk and needs based criteria and enrolled in a HARP. Definitions of these services may be found in Attachment C on page 95.

D. NYS anticipates that rehabilitation services for residents of community residences will be phased in to the capitation rate in year two.

E. Concurrent with the Demonstration Amendment, NYS requested a State Plan Amendment (SPA) to move SUD clinic services to the rehabilitation option to provide services in a more recovery-oriented model and to add residential SUD services to ensure that Medicaid individuals have a full array of SUD services available to them.

F. Cost-sharing will be unchanged from the current Medicaid FFS-approved State Plan. There is no nominal Medicaid cost-sharing approved in the State Plan for mental health or SUD services.

G. The Plan will ensure that the member is offered all eligible benefits.

H. Medicaid covered services will be available throughout the service area covered by the Plan and provided by the Plan's contracted providers, using the NYS Medicaid definition of "medically necessary services".

I. For all modalities of care, the duration of treatment will be determined by the member's needs and his or her response to treatment. All services, for which a member is eligible, will, at a minimum, cover:

   i. The prevention, diagnosis, and treatment of health impairments;

   ii. The ability to achieve age-appropriate growth and development; and

   iii. The ability to attain, maintain, or regain functional capacity.

J. During the term of the contract, the Plan may provide cost-effective services that are in addition to those covered under the Medicaid State Plan as alternative treatment services and programs for enrolled members under 42 CFR 438.6(e).

i. The Plan must perform a cost-benefit analysis for any new services it proposes to provide, as directed by NYS, including how the proposed service would be cost-effective compared to the State Plan services.

ii. The Plan can implement cost-effective services and programs only after approval by NYS.

iii. The Plan is encouraged to assist NYS to develop cost-effective alternatives for acute services.

K. MCOs may utilize telemedicine for Medicaid State Plan services to the extent that it is medically appropriate and permissible in the FFS program, including compliance with all federal requirements.

1.11 Rates

A. All capitation payments will be subject to actuarially soundness per 42 CFR 438.6(c).

B. For individuals enrolled in mainstream MCOs, a distinct BH rate calculation will be applied for each existing premium group.

C. For individuals enrolled in a HARP, NYS will establish an appropriate premium group and an integrated BH/PH capitation payment will be determined.

D. Historical eligibility, FFS claims and health plan encounter data will be considered in developing appropriate base data for rate setting during the initial rating periods. As health plan experience emerges and is deemed to be sufficiently credible and reasonable, the base data for rate-setting will increasingly rely on actual health plan experience data.

E. In order to develop appropriate base data for rate setting, the historical data will be adjusted for factors including, but not limited to:

a. Incurred But Not Reported (IBNR) and/or Reported But Unpaid Claims (RBUCs).

b. Encounter data completeness.

c. Smoothing of anomalies in the data related to lack of credibility and/or non-recurring phenomenon within the historical time period.

d. Retroactive payment adjustments not otherwise reflected.

F. In order to develop capitation rates, the rate setting base data will be adjusted for factors including, but not limited to:

a. Program changes occurring between the beginning of the base data period and the end of the contract period.

b. Utilization and unit cost trend between the base period and the contract period.

c. Differences in expected costs associated with the transition from FFS to managed care and/or expectations around managed care efficiencies (as applicable).

d. Non-medical expenses, including costs associated with administrative functions, care management and underwriting gain.

G. Final capitation rates will also be adjusted to account for any applicable withholds or risk sharing mechanisms that are a part of the program.

H. Until such time as actual health plan experience is available and meets credibility/ reasonability standards for rate-setting, the cost of “in-lieu of”/cost effective alternative

services per 42 CFR 438.6(e) will not be included in capitated rate calculations. NYS will only factor the State Plan services into the rates. Once health plan experience that inherently reflects the cost of "in-lieu of" services is integrated into rate-setting, these costs will be allowed to remain in the base so long as they are determined to be cost effective.

Note: Draft Rates will be released at a later date

1.12 Historical Utilization and Cost

Data on historical utilization can be found in the behavioral health databook. The databook will be posted on the OMH, OASAS, and DOH websites and the public will be notified through the MRT listserve when it is available.

Table 1. Benefits in Mainstream MCOs for all Medicaid Populations over the age of 20

Services	Current State Plan	SPA Change Submitted Separately from this 1115 Demonstration Amendment but for Inclusion in This Demonstration	Currently in NYS 1115 Benefit Package	Current delivery System (Either MCO or FFS)	Future MCO Benefit Package
Medically supervised outpatient withdrawal (OASAS services)	Yes	Rehabilitation option per 42 CFR 440.130	Yes	Managed care for MCO enrollees; FFS for non-MCO enrollees	Yes for MCO enrollees
Outpatient clinic and opioid treatment program (OTP) services (OASAS services)	Yes — clinic option per 42 CFR 440.90	Move to rehabilitation option per 42 CFR 440.130	Outpatient clinic and OTP is FFS for all Medicaid enrollees	FFS under clinic option	Yes for MCO enrollees
Outpatient clinic services (OMH services)	Yes — clinic option per 42 CFR 440.90		Temporary assistance to needy families (TANF) and safety net assistance (SNA) only;	Managed care for TANF and SNA; FFS for SSI and duals	Yes for MCO enrollees
Comprehensive psychiatric emergency program	Yes — outpatient hospital service (42 CFR 440.20)		TANF and SNA only; FFS for all SSI Medicaid recipients	Managed care for TANF and SNA; FFS for SSI and duals	Yes for MCO enrollees
Continuing day treatment	Yes — clinic option per 42 CFR 440.90		No	FFS only	Yes for MCO enrollees
Partial hospitalization	Yes — clinic option per 42 CFR 440.90		No	FFS only	Yes for MCO enrollees
PROS	Yes — rehabilitation option per 42 CFR 440.130		No	FFS only	Yes for MCO enrollees
ACT	Yes — rehabilitation option per 42 CFR 440.130		No	FFS only	Yes for MCO enrollees
Intensive case management/ supportive case management	Yes — TCM is being phased out; now using Health Home SPA authority		No	FFS only	Yes for MCO enrollees

Services	Current State Plan	SPA Change Submitted Separately from this 1115 Demonstration Amendment but for Inclusion in This Demonstration	Currently in NYS 1115 Benefit Package	Current delivery System (Either MCO or FFS)	Future MCO Benefit Package
Health home coordination	Yes — Health Home per 1945 of Social Security Act		No	Managed care for MCO enrollees; FFS for non-MCO enrollees	Yes for MCO enrollees
Inpatient hospital detoxification (OASAS service)	Yes — inpatient 42 CFR 440.10		Yes	Managed care for MCO enrollees; FFS for non-MCO enrollees	Yes for MCO enrollees
Inpatient medically supervised inpatient detoxification (OASAS Service)	Yes — inpatient 42 CFR 440.10		Yes	Managed care for for MCO enrollees; FFS for non-MCO enrollees	Yes for MCO enrollees
Inpatient treatment (OASAS service)	Yes — inpatient 42 CFR 440.10		TANF and SNA only; FFS for all SSI Medicaid recipients	Managed care for TANF and SNA; FFS for SMI, SSI and duals.	Yes for MCO enrollees
Rehabilitation services for residential SUD treatment supports (OASAS service)	No	Rehabilitation option per 42 CFR 440.130	No	FFS	Yes for MCO enrollees
Inpatient psychiatric services (OMH service)	Yes — inpatient 42 CFR 440.10		TANF and SNA only; FFS for all SSI Medicaid recipients	Managed care for TANF and SNA; FFS for SSI and duals	Yes for MCO enrollees
Rehabilitation services for residents of community residences	Yes — rehabilitation option per 42 CFR 440.130		No	FFS	Yes for MCO enrollees in year 2

Table 2: HCBS Services for Adults Meeting Targeting and Functional Needs

Services	Currently in the Medicaid State Plan	Proposed Under this 1115 Demonstration Amendment as a 1915(i)-Like Service	Future HARP Benefit Package for Adults Meeting Targeting and Functional Criteria
Rehabilitation • Psychosocial Rehabilitation • Community Psychiatric Support and Treatment (CPST) • Crisis Intervention	No	Yes	Yes
Peer Supports	No	Yes	Yes
Habilitation • Habilitation • Residential Supports in Community Settings	No	Yes	Yes
Respite • Short-term Crisis Respite • Intensive Crisis Respite	No	Yes	Yes
Non-medical transportation	No	Yes	Yes
Family Support and Training	No	Yes	Yes
Employment Supports • Pre-vocational • Transitional Employment • Intensive Supported Employment • On-going Supported Employment	No	Yes	Yes
Education Support Services	No	Yes	Yes
Supports for self-directed care [phased in as a pilot; see details below] • Information and Assistance in Support of Participation Direction • Financial Management Services	No	Yes	Yes

2.0 Definitions

ACA — Affordable Care Act.

ACT — Assertive Community Treatment.

Adults — Individuals age 21 and over.

BH — Behavioral health, which is inclusive of mental health and substance use disorder benefits and/or conditions.

BHO — Behavioral health organization.

BH professional (BHP) — An individual with an advanced degree in the mental health or addictions field who holds an active, unrestricted license to practice independently or an individual with an associate's degree or higher in nursing who is a registered nurse with three years of experience in a mental health or addictions setting. Throughout the request for qualifications, the BHP will be specified as either a New York State or U.S. BHP. When specified as a New York State BHP, the individual must hold an active, unrestricted license to practice independently in New York State or be a registered nurse in New York State. When specified as a U.S. BHP, the individual may meet the licensure requirement with an active, unrestricted license to practice independently or be a registered nurse in any state in the U.S.

BH Service — Any or all of the services identified in Table 1 and Table 2 of this RFQ.

Business day — Traditional workdays include Monday, Tuesday, Wednesday, Thursday, and Friday. State holidays are excluded and traditional work hours are 8 am–6 pm.

Care coordination — Deliberate organization of member care activities by a person or entity (e.g., Health Homes) formally designated as primarily responsible for coordinating services furnished by providers involved in a member's care. This coordination may include care provided by network or non-network providers. Organizing care involves the marshaling of personnel and other resources needed to carry out all required member care activities; it is often facilitated by the exchange of information among participants responsible for different aspects of the member's care.

Care management — Overall system of benefit package service/management administered by the Plan and which encompasses utilization management, care coordination, facilitating continuity of care during care transitions (i.e., changes in levels of care, aging out of the Children's System of Care or member relocation), management of the quality of care, chronic condition management, and independent peer review.

CASAC - Credentialed Alcoholism and Substance Abuse Counselor as defined by OASAS in 14 NYCRR Part 853.

Case management — A network service delivered by a Health Home provider or Targeted Case Manager as defined in the State Plan.

CEO — Chief executive officer.

CI — Confidence interval.

Clinical practice guidelines — Systematically developed statements regarding assessment and intervention practices to assist practitioner and patient/consumer decisions about appropriate health care for specific circumstances. The goals of clinical practice guidelines are to describe appropriate care based on the best available scientific evidence and broad consensus; reduce inappropriate variation in practice; provide a more rational basis for referral; provide a focus for continuing education; promote efficient use of resources; act as a focus for quality control, including audit and highlight shortcomings of existing literature and suggest appropriate future research.[7]

CMO — Chief medical officer.

CMS — The Centers for Medicare and Medicaid Services.

Community Inclusion — The full participation by an individual living with mental illness and/or substance use disorders in activities, organizations and groups of his/her choosing in the community.

Consumer — A member who is receiving or has received mental health/substance use disorder services under the Contract.

Delegated entity — Any parent, subsidiary, affiliate , or other related organization, with which the responder intends to partner or subcontract for administrative or management services required under the request for qualifications.

Evidence-based practice (EBP) — Clinical interventions that have demonstrated positive outcomes in several research studies to assist individuals in achieving their desired goals of health and wellness.

ED — Emergency department.

First Episode Psychosis (FEP) — First Episode Psychosis (FEP) -- Members with FEP are individuals who have displayed psychotic symptoms suggestive of recently-emerged schizophrenia. FEP generally occurs in individuals age 16-35. For this RFQ, FEP includes individuals whose emergence of psychotic symptoms occurred within the previous 2 years, who remain in need of mental health services, and who have a diagnosis of schizophrenia, schizoaffective disorder, schizophreniform disorder, psychotic disorder NOS (DSM-IV), or other specified/unspecified schizophrenia spectrum and other psychotic disorder (DSM-5). The definition of FEP excludes individuals whose psychotic symptoms are due primarily to a mood disorder or substance use.

FFS — Fee-for-service.

FHPlus — Family Health Plus.

FTE — Full-time Equivalent Employee.

HARP — Health and Recovery Plan.

HCBS — Home- and community-based services

[7] Source: http://www.openclinical.org/guidelines.html Source.

I/DD — Intellectual and developmental disability.

Level of care guidelines — Written criteria designed for use by qualified BH professionals in making level of care decisions based on an individual's symptoms, history, likelihood of treatment response , available resources and other relevant clinical information. The purpose of the level of care determination is to assure that a client in need of service is placed in the least restrictive, but most clinically appropriate level of care available, consistent with NYS medical necessity criteria. May also be called placement criteria.

LGU – Local Governmental Unit as defined under Article 41 of the NYS Mental Hygiene Law. Each LGU has a Director of Community Services responsible for among other things the oversight and planning of the local (county/NY city) mental hygiene system. This includes mental health, substance use, and developmental disability services.

LOC — Level of care.

LOCADTR- "Level of care for alcohol and drug treatment referral" is the patient placement criteria system required for use in making SUD level of care decisions in NYS.

LON — Level of need.

LTC — Long term care.

Managed Care Plans — Includes the Qualified Mainstream Plans, Managed Care Organizations, and Health and Recovery Plans.

MCO — Managed care organization.

MH — Mental health.

MLR —Medical Loss Ratio (MLR) is the percent of premium an insurer spends on claims and expenses that improve health care quality. New York State will determine what qualifies as an eligible claim and expense for determining medical loss ratios.

MM — Medical management.

Natural supports — Relationships that occur in everyday life in the community where a consumer lives and works. Natural supports can include, but are not limited to family members, friends, neighbors, clergy, and other acquaintances. Such supports help consumers develop a sense of social belonging, dignity, and self-esteem.

NYC — New York City.

NYS — New York State.

OASAS — The Office of Alcoholism and Substance Abuse Services.

OMH — The Office of Mental Health.

OPWDD — The Office for People with Developmental Disabilities.

OTP — Opioid treatment program.

P&P — Policy and procedure.

PCP — Primary care provider.

Peer Specialist — are individuals who hold a credential from a certifying authority recognized by the commissioner of OASAS or OMH. Peer specialists are supervised by a credentialed or licensed clinical staff member to provide peer support services or other authorized services based on clinical need as identified in the patient's treatment/recovery plan.

Permanent supportive housing (PSH) — Housing with continued occupancy for a qualified tenant as long as the tenant's household pays the rent and complies with the lease or applicable landlord/tenant laws. The tenants are linked with supportive services that are: flexible and responsive to their individualized needs; available when needed by tenants; and accessible where the tenant lives, if necessary. Housing meets the U.S. Department of Housing and Urban Development housing quality standards and is made available by New York State, or its designee, or directly with other qualified housing organizations. Housing is affordable to the eligible target population (monthly rent and utilities do not exceed 30% of monthly income).

PH — Physical health.

PIP — Performance improvement project.

The Plan — For the purposes of this request for qualifications, the term Plan refers to the managed care organization and Health and Recovery Plan (HARP) collectively. Any requirement under the request for qualifications that references the Plan shall apply to both the Health and Recovery Plan (HARP) and the managed care organization. Requirements that reference only the Health and Recovery Plan shall apply only to the Health and Recovery Plan.

PMPM — Per member per month.

PROS — Personalized Recovery Oriented Services.

QARR — Quality Assurance Reporting Requirements.

QM — Quality management.

QMP- Qualified Mainstream Plan meets the qualifications established by this RFQ to manage behavioral health services for Medicaid beneficiaries.

RPC – Regional BH planning Consortiums (RPC) comprised of each LGU in a region, and representatives of mental health and substance use disorder service providers, child welfare system, peers, families, health home leads, and Medicaid MCOs. The RPC would work closely with State agencies to guide behavioral health policy in the region, problem solve regional service delivery challenges, and recommend provider training topics.

RFQ — Request for qualifications.

SAMHSA — Substance Abuse and Mental Health Services Administration.

SDOH — The State Department of Health.

Semi-annual — Twice yearly.

Serious mental illness (SMI) — A diagnosable mental disorder experienced by an adult that is sufficiently severe and enduring to cause functional impairment in one or more life areas and a recurrent need for mental health services.

SMA — The State Medicaid Agency. In NYS this is the NYS Department of Health.

SNA — Safety net assistance.

Start-up date — The date the managed care organization or Health and Recovery Plan providers begin providing behavioral health services identified in the request for qualifications. Also referred to as the "go-live date".

SPA — State Plan Amendment.

SSI — Social Security Income.

State — State of New York

SUD — Substance use disorder.

TANF — Temporary assistance to needy families.

Transition age youth (TAY) — Individuals under age 23 transitioning into the adult system from any OMH, OASAS or OCFS licensed, certified, or funded children's program. This also includes individuals under age 23 transitioning from State Education 853 schools.

TCM — Targeted case management.

Utilization management (UM) — Procedures used to monitor or evaluate clinical necessity, appropriateness, efficacy, or efficiency of behavioral health care services, procedures, or settings and includes ambulatory review, prospective review, concurrent review, retrospective review, second opinions, care management, discharge planning, and service authorization.

Utilization review (UR) — Utilization review means the review to determine whether health care services that have been provided, are being provided or are proposed to be provided to a patient, whether undertaken prior to, concurrent with or subsequent to the delivery of such services are medically necessary.

WRAP — Wellness Recovery Action Plan.

3.0 Performance Standards

A. Plans must meet the qualifying criteria in this RFQ to manage the delivery of Medicaid behavioral health services. This may be done independently or by partnering/contracting with experienced providers or by subcontracting with a BH organization.

B. This document lists criteria that are in addition to present MCO requirements as delineated by the model contract. These existing requirements remain in place and must be met unless explicitly modified per this document.

C. In the sections that follow, the requirements for all managed care plans are specified. Additional qualifying criteria must also be met to operate a HARP and administer enhanced home and community based services benefits (1915(i)-like benefits).

D. The criteria outlined below are draft. They are subject to change based on feedback from the RFI and negotiation with the federal government.

3.1 Organizational Capacity

The Plan must meet the following minimum requirements:

A. The Plan must be operating as a Medicaid MCO in NYS as of March 1, 2013 and on the start-up date[8].

B. The Plan or its business associates may not have current, unsatisfied charges or orders outstanding against it by any State or the federal government related to administration of BH services.

C. The Plan or its business associates may not have had a contract to manage BH services discontinued, cancelled or non-renewed for lack of performance or non-performance within the prior three years.

D. The Plan must demonstrate that they have processes and procedures to accommodate the service needs of people with both BH and PH conditions.

E. In addition to current MCO operations, the Plan must establish BH-specific service center operations in NYS by the start-up date. This should be co-located with an established Plan service center in NYS where available and appropriate.

F. The Plan shall provide and/or manage the functions listed below. Unless otherwise noted, functions shall be available during business hours (8 am to 6 pm) in the NYS BH service center location.

   i. 7 days a week, 365 days a year toll-free line to provide information and referral on BH benefits and services.

   ii. 24 hour, 7 days a week, 365 days a year person staffed toll-free line to provide crisis referral.

[8] A Plan merger creating a new Plan will not disqualify that new Plan from managing the behavioral health benefits.

iii. BH network development, management and contracting, except credentialing/ recredentialing may be done at another location.

iv. BH provider relations with staff access to a claims reporting and payment reporting platform (claims may be administered at another location).

v. BH utilization reviews with 24 hour, 7 days a week access to appropriate personnel to conduct prior authorization. Per federal guidelines, the MCO must respond to prior authorization requests for post stabilization services within 1 hour (24 hours a day).

vi. BH care management consistent with requirements at 42 CFR 438.208(c).

vii. BH clinical and medical management as specified in Sections 3.9 and 3.10.

viii. Education and training on topics required under this RFQ for medical and BH providers, State staff and other member serving agencies, except for specialized training where the Plan engages trainers with specialized expertise. Whenever possible, training and education for providers should be provided in coordination with the Regional Planning Consortiums (RPCs).

ix. BH resources to assist with BH-specific quality management (QM) initiatives, financial oversight, reporting and monitoring, and oversight of any subcontracted or delegated function.

G. The Plan must have an established technology platform that provides technology support to comply with requirements under this RFQ, including demonstrated success in:

i. Data exchange with any business associate that will perform activities required under the RFQ.

ii. Provision of web-based portals with appropriate security features that allow BH providers and State agencies to submit and receive responses to BH referrals and requests for prior authorizations for BH services.

iii. Data-driven approaches to monitor requirements described in the RFQ, by eligibility group when appropriate, including BH network adequacy, crisis plans, psychiatric advance directives, and BH-specific reporting requirements for UM, QM, and financial management as well as administrative and clinical performance metrics.

3.2 Experience Requirements

A. The Plan or its business associate must have more than five years of experience with Medicaid BH managed care programs including the following:

i. Demonstrated success with the implementation of complex public sector BH managed care programs in an efficient and effective manner.

ii. Demonstrated success with the ongoing management of full risk Medicaid contracts that include BH services that are comparable in scope to the requirements under this RFQ.

iii. Experience coordinating non-Medicaid funded care for Medicaid BH service recipients including coordination with local, State, and federal/other grant funded BH programs and supports (e.g., Substance Abuse Prevention and Treatment and Community Mental Health Services Block Grants).

iv. Experience and demonstrated success in building and/or transforming a network delivery system to embrace principles of wellness and recovery, as demonstrated by:

   a. The development of a qualified culturally competent provider network that emphasizes evidence-based and promising practices.
   b. The incorporation of the preferences of members and their families in the design of services and supports.
   c. The incorporation of a holistic approach in the design and delivery of services and supports, including assisting the member with obtaining and maintaining stable, safe, permanent housing; meaningful employment; social networks; and health and wellness.
   d. Success in collaborating with consumer and/or family-run services, demonstrated by incorporating peer-run and family-run services into the provider network.
   e. The use of self-management and relapse prevention skills, wellness recovery action Plan (WRAPs), and psychiatric advance directives.
   f. Experience and demonstrated success in operating a utilization and care management program for a comprehensive array of BH programs and services similar to those covered under the core benefit package described in this RFQ as demonstrated by successful reduction of inappropriate admissions and readmissions to the emergency room, inpatient, or other 24-hour levels of care for psychiatric or addiction disorders.

v. Experience in providing services to other Medicaid or government-sponsored Plans for members and populations similar to the covered members under this RFQ as demonstrated by:

   a. Expertise managing the full range of services for individuals with primary or co-occurring SUDs, including experience managing methadone and buprenorphine and other addiction medications.
   b. Expertise with the management and oversight of mental health polypharmacy as well as individuals taking injectable antipsychotics.
   c. Expertise managing BH care for special populations including, but not limited to adults with co-occurring I/DD and/or chronic medical conditions or transition-aged youth.
   d. Experience and demonstrated success in implementing BH medical integration initiatives as evidenced by documented improvements in clinical and financial outcomes across the health care spectrum and communication/coordinated Plan of care development between medical and behavioral providers.

g. Experience in implementing BH-specific performance improvement projects and valid, reliable performance metrics, including examples of successful achievement of performance thresholds or guarantees that embody the system goals and operating principles outlined in this document.

B. **Alternative Demonstration of Experience**: If a Plan can't demonstrate the required experience described in 3.2 above, it can contract with a Behavioral Health Organization or partner with an experienced vendor. The State will consider alternative experience on a case by case basis. Plans may submit the names and experience of senior employees to be assigned to manage the BH benefit who have the required expertise including a minimum of five years of experience in the areas stated above.

Additionally, Plans may submit their experience managing care for other high need populations or complex benefits in NYS or elsewhere. For example:

i. Managed long term care (MLTC)

ii. HIV SNP

iii. Homeless

iv. Forensic BH

v. Waiver services, peer supports, or community rehabilitation for disabled populations

Plans must provide details on how this experience qualifies them to manage BH benefits and networks in NYS and provide a reasonable plan for how this experience will be operationalized to meet the needs of people with serious behavioral health conditions.

C. **In addition to the above minimum organizational and experience requirements, HARPs must also meet the following additional requirements**:

i. The HARP shall have a proven track record in providing services to Medicaid or other government-sponsored Plans for members and populations similar to those described under the home and community based services 1915(i)-like component of the Demonstration Amendment as demonstrated by:

a. Experience and demonstrated success managing BH care for special populations including, but not limited to adults with SMI, adults with functionally limiting SUD, individuals experiencing a first episode psychosis, individuals with SMI and criminal justice involvement, adults residing in permanent supportive housing (PSH) or other types of community housing and homeless adults.

b. Experience and demonstrated success in operating a comprehensive care management program for HARP like populations.

ii. The HARP shall have a reasonable plan and sufficient internal resources with the relevant expertise to customize their technology platform to support compliance with federal HCBS requirements under the 1915(i)-like component of the 1115 waiver Demonstration Amendment. This includes evaluating the adequacy of plans of care

compared to assessed needs and that services are delivered consistent with the plan of care.

iii. A reasonable plan and sufficient internal resources to review external functional assessments, service eligibility determinations, and plans of care for SMI and/or SUD populations.

iv. The HARP shall have a BH advisory subcommittee (for each region corresponding with RPCs) reporting to the MCO's governing board. The subcommittee will include peers, providers, and other key stakeholders.

D. **Alternative Demonstration of Experience for HARPS**: If a Plan can't demonstrate the required experience for a HARP described above, it can contract with a Behavioral Health Organization or partner with an experienced vendor. The State will consider alternative experience on a case by case basis. Plans may submit the names and experience of senior employees to be assigned to manage the HARP BH benefit who have a minimum of five years of experience in the areas stated above. Additionally, Plans may submit their experience managing similar types of care for other Medicaid high need populations or complex benefits including the development of information systems for populations utilizing HCBS services.

Plans must provide details on how this experience qualifies them to manage HCBS BH services in NYS and provide reasonable plan for how this experience will be operationalized to meet the needs of people in HARPs with serious behavioral health conditions. Plans may include a description of how their network contract relationships will help them meet the objectives of the State identified in this RFQ.

3.3 Contract Personnel

A. The Plan shall have BH resources sufficient to meet all contract requirements and performance standards and shall require that all staff have the training, education, experience, orientation, and credentials, as applicable, to perform assigned job duties. Proposals must contain specific details on how the functions will be assigned and how Plans will ensure these functions are effectively achieved in ways that ensure effective services are provided to people with serious behavioral health conditions.

Attachment D lists minimum requirements for key personnel, managerial staff, and other staff for the MCO's Qualified Mainstream Plan and HARP product lines, including requirements for dedication to NYS Medicaid, restrictions on sharing staff between the BH or HARP lines of business and whether the position must be fulltime or located in NYS. Detailed functional responsibilities for these positions are described below. Unless otherwise noted, these positions shall be located in the NYS service center location.

B. The Plan shall employ the following key personnel to oversee BH benefits for individuals enrolled in its Qualified Mainstream Plan product line. Plans must designate one of these key personnel to have overall accountability for the BH MCO product line. This position must

be reflected in the Plan's organizational chart and the identified individual must have appropriate managerial experience.

i. **Behavioral Health Medical Director(s)**: The Qualified Mainstream Plan Behavioral Health Medical Director(s) shall hold a NYS license as a physician and shall have a minimum of 5 years of experience working in BH managed care settings or BH clinical settings for both general psychiatry and addiction disorders. Preferably, the medical director(s) shall be full-time and board certified in general psychiatry and addiction disorders (Certification in Addiction Medicine or Certification in the Subspecialty of Addiction Psychiatry). If the Plan does not offer a HARP product line, it is likely the Plan will need to hire two part-time positions to separately cover psychiatry and addictions expertise.

   If the Plan offers a HARP product line, the Plan must also have a HARP Behavioral Health Medical Director (see below). One of these positions must be boarded in psychiatry and the other must have addictions certification. These positions should be full-time positions and solely dedicated to the MCO and HARP product lines.

ii. **Behavioral Health Clinical Director**: The Qualified Mainstream Plan Behavioral Health Clinical Director shall hold a NYS license as a BH professional (BHP) and have at least seven years of experience in a BH managed care setting or BH clinical setting, including 2 years of managed care experience (preferably Medicaid managed care). The BH Clinical Director will be dedicated solely to the work of the BH MCO and is a full-time position if the Plan does not offer a HARP product line (see below "HARP Clinical Director").

iii. The BH Medical Director(s) and BH Clinical Director shall be involved in the following functions related to eligible members under the RFQ:

   a. Development, implementation, and interpretation of clinical-medical policies and procedures that are specific to BH or can be expected to impact the health and recovery of BH consumers.

   b. Ensuring strong collaboration and coordination between physical and behavioral health care.

   c. Clinical peer reviewer recruitment and supervision.

   d. Provider recruitment, education, in-service training, and orientation.

   e. Decision-making process for BH provider credentialing decisions.

   f. BH provider quality profile design and data interpretation.

   g. Development and implementation of the BH sections of the QM/UM Plan, including having a medical director serve as the chairperson of BH committees for QM/UM and peer review.

   h. Administration of all BH UM/QM and performance improvement activities, including grievances and appeals.

i. Attendance at regular (at least quarterly) medical director meetings designated by the State BH contract manager.

j. Attendance at Regional Planning Consortium meetings.

C. **Changes in Key Plan Staff**: The Plan shall verbally inform the State BH contract manager immediately and provide written notice within seven days after the date of a resignation or termination of any of the key personnel listed above, including the name of the interim contact person that will be performing the key personnel member's duties. In addition, the Plan shall submit a written Plan for replacing key personnel, including expected timelines. If key personnel will not be available for work under the RFQ for a continuous period exceeding 30 days, or are no longer working full-time in the key position, the Plan shall notify the State BH contract manager within seven days after the date of notification by the key personnel of the change in availability or change in full-time employment status.

D. **Managerial Staff:** The Plan shall employ managerial personnel to oversee and provide the functions listed below. Some of the positions are required to work full-time at sites located in NYS, with their work dedicated solely to the performance of work under the RFQ, as noted in Attachment D. For other positions, the Plan may employ staff located outside NYS or not solely dedicated to work under this RFQ. In such instances, the location and proportion of time dedicated to perform work related to the performance of this Contract must be specified and approved by the State.

i. **BH utilization/care management**: Plans shall provide care management to individuals with SMI, SUD, co-occurring physical health, co-occurring disorders of MH and SUD, and co-occurring MH disorders and I/DD. The individual responsible for oversight of utilization/care management must be a U.S. BHP with experience working in a BH managed care setting or BH clinical setting and must work at sites located in NYS. This individual's responsibilities will be dedicated only to behavioral health. Larger plans will be required to describe adequate supervisory resources. The Plan must note and provide a rationale for the full time equivalent (FTE) % effort dedicated to this role.

ii. **BH network development**: Plans shall assure network adequacy and appointment access, development of network resources in response to unmet needs and new service development as specified in the benefit package, adequacy of the provider network to provide member choice of providers, and contracting with qualified service providers in compliance with federal and State laws and the requirements set forth in this Contract, including all documents incorporated by reference. The individual(s) providing oversight for network development should have experience working in a BH managed care setting or BH clinical setting, and demonstrated expertise in network development for MH and SUD services for:

a. Adults;

b. Transition age youth;

c. High risk groups such as individuals with SMI, co-occurring major mental disorders and SUDs and those involved in multiple services systems (education, justice, medical, welfare, and child welfare);

d. Individuals with I/DD in need of BH services;

e. Individuals with a MH condition or a SUD and co-occurring chronic physical health conditions; and

f. Individuals with a SUD in need of medication-assisted treatment, including methadone and buprenorphine for opioid dependence.

Experience should include knowledge of integrated physical health and behavioral health, recovery-oriented practices and development of EBPs recognized by the Substance Abuse and Mental Health Services Administration (SAMHSA) and other national registries, including supportive housing and supported employment.

The individual(s) shall be responsible for network development, contracting, credentialing, and provider communications. The Plan must note and provide a rationale for the full time equivalent (FTE) % effort dedicated to BH network development oversight. This position must work at sites located in NYS.

iii. **BH provider relations**: The Plan is responsible for assuring timely inter-provider referrals and associated appointment access; assisting in resolving provider grievances, disputes between providers and the investigation of member grievances regarding providers; coordinating provider site visits, reviewing provider profiles, and implementation and monitoring of corrective action Plans, as needed; and assuring accuracy of provider service delivery reports (i.e., encounter information verification). The individual(s) providing oversight for these functions should have experience working in a BH managed care setting or BH clinical setting and expertise in the management of provider BH services for:

a. Adults;

b. Transition age youth;

c. High risk groups such as individuals with SMI, co-occurring major mental disorders and SUDs and those involved in multiple services systems (education, justice, medical, welfare, and child welfare);

d. Individuals with I/DD in need of BH services;

e. Individuals with a MH condition or a SUD and co-occurring chronic physical health conditions; and

f. Individuals with a SUD in need of medication-assisted treatment, including methadone and buprenorphine for opioid dependence.

Experience should include knowledge of recovery-oriented practices and development of EBPs recognized by the SAMHSA and other national registries. EBPs include but are not limited to wellness self-management, supported employment, family

psychoeducation, ACT, and IDDT. The Plan must note and provide a rationale for the FTE % effort dedicated to provider relations activities. Personnel responsible for these functions must work at sites located in NYS.

vi. **BH Training**: Plans must ensure development and implementation of training programs for Plan staff, network providers and staff of other State agencies that deliver, coordinate, or oversee services to enrolled persons. Plans must work closely with RPCs as well to ensure regional provider training priorities are met. The individual(s) responsible for BH training should have significant experience and expertise in developing training programs related to BH systems and familiarity with recovery-oriented services. This individual shall oversee subcontracted trainers, design and implement training programs, and monitor training program effectiveness. The Plan must note and provide a rationale for the FTE % effort dedicated to BH training oversight.

vii. **BH Quality Management**: Plans are responsible for the development of the BH section of the Plan's QM/UM Plan and its effective implementation in collaboration with the Plan's clinical and utilization/care management leadership, and also in compliance with federal and State laws and the requirements set forth in this Contract, including all documents incorporated by reference. The individual(s) responsible for BH Quality Management should have familiarity with recovery-oriented services as well as experience and expertise in quality improvement in the public sector MH and addictions programs and publicly funded managed BH care delivery systems. The Plan must note and provide a rationale for the FTE % effort dedicated to BH Quality Management oversight, and this position must work at sites located in NYS.

viii. **BH information systems**: Plans must oversee all data interfaces and support the reporting requirements required by this Contract, provide oversight of the management information systems requirements, and ensure compliance with federal and State laws and the requirements set forth in this Contract, including all documents incorporated by reference. The individual(s) responsible for oversight should have significant experience and expertise in Medicaid data analytics and BH data systems. The Plan must note and provide a rationale for the FTE % effort dedicated to BH IT oversight, and this position must work at sites located in NYS.

ix. **Governmental/community liaison** to work with New York State, county behavioral health leadership, and RPCs within its service area. Plan representatives should attend relevant stakeholder, planning, and advocacy meetings and communicate/coordinate with other staff in the Plan as necessary to ensure that the Plan is aligned with NYS and local BH initiatives.

E. In addition to the key and managerial personnel, the Plan shall have a sufficient number of qualified supporting staff to meet the responsibilities of this RFQ, including sufficient experience and expertise in working with the eligible members served under this RFQ. These staff shall work at sites located within NYS, with the exception of claims staff and BH clinical peer reviewers, who may be hourly consultants located outside NYS. The Plan shall

have a sufficient number of staff, at a minimum, in the following categories and shall provide the State with the staffing formula:

i. **Utilization/care management staff** to be available, seven days per week to conduct prior authorization, concurrent review and retrospective review and to provide related authorization of BH care when medically necessary and to provide ongoing care management for members. All utilization/care management staff must be U.S. licensed BHPs. Some of these staff should include individuals who are Certified Alcohol and Substance Abuse Counselors for concurrent review of SUD services. Utilization/care management staff shall have experience and expertise in managing care for one or more of the following populations:

   a. Adults with behavioral health needs;

   b. Transition age youth with behavioral health needs;

   c. Older adults with a MH condition or a SUD;

   d. High risk groups such as individuals with SMI, co-occurring major mental disorders and SUDs and those involved in multiple services systems (education, justice, medical, welfare, and child welfare);

   e. Individuals with I/DD in need of BH services;

   f. Individuals with a MH condition or a SUD and co-occurring chronic physical health conditions;

   g. Individuals with a SUD in need of medication-assisted treatment, including methadone and buprenorphine for opioid dependence.

   All admission and continued stay authorization decisions are made by a U.S. BHP with a minimum of three years of clinical experience in a BH setting.

ii. **BH clinical peer reviewers**, who meet the criteria for one of the following categories, to conduct denial and appeal reviews, peer review on psychological testing or complex case review and other consultation on member strengths and treatment needs:

   a. Physicians who are board certified in adult psychiatry.

   b. Physicians who hold a Certification in Addiction Medicine or a Certification in the Subspecialty of Addiction Psychiatry.

   c. Licensed doctoral level psychologists.

iii. **BH QM specialists** to implement the BH section of the QM/UM Plan and to track, review, and investigate critical incidents and accidents, morbidities, mortalities, and other quality of care issues. QM staff must have relevant regulatory, QM, managed care or clinical BH experience and may include licensed BHPs and CASACs.

iv. **Provider relations staff** to meet requirements under this RFQ for appropriate provider education about network participation requirements, provider training, provider profiling, and provider performance improvement or problem resolution. Plans operating in NYC

must locate a sufficient number of provider relations staff within the City. Plans need to indicate how many provider relations FTE staff will be employed and where they will be located.

v. **Additional staff, as needed**, to provide liaison with other member-serving systems including, but not limited to:

   a. OMH;

   b. OASAS;

   c. OPWDD;

   d. NYC Department of Health and Mental Hygiene;

   e. State and local criminal justice agencies;

   f. Juvenile justice for justice involved Transition Age Youth;

   g. State and local housing and homeless services and local housing administrators.

   h. Vocational Administration;

   i. County administrators or staff.

vi. A sufficient number of qualified staff to meet both new contract requirements and increased volume including administrative and support staff, member services staff, grievance and appeal staff, claims staff, encounter processing staff, data analysts, and financial reporting analysts.

F. The Plan shall maintain current organization charts and written job descriptions for each functional area consistent in format and style.

   i. These organization charts and job descriptions must be submitted for review by NYS.

   ii. The Plan shall hire employees for the key and required BH positions specified throughout Section 3.3 of this RFQ.

   iii. Consultants shall not fill these positions without the approval of the State.

   iv. The Plan shall develop and maintain a human resources and staffing plan that describes how the Plan shall maintain the staffing level to ensure the successful accomplishment of all duties outlined in the RFQ. The key personnel and required personnel listed in the RFQ are mandatory positions.

   v. The Plan may propose a staffing plan that combines positions and functions outlined in the RFQ with other positions as long as the Plan describes how the table of organization and staff roles delineated in the RFQ will be addressed.

   vi. Submission of organizational charts and job descriptions will be due to the State 90 days before the implementation date.

G. All personnel necessary to carry out the terms, conditions, and obligations of this Contract are the responsibility of the Plan. The Plan shall recruit, hire, train, supervise and, if

necessary, terminate such professional, paraprofessional, and support personnel as necessary to carry out the terms of this Contract.

H. Any BH clinical peer reviewer who is subcontracted or works in a service center other than Plan's NYS service center shall be subject to the same supervisory oversight and quality monitoring as staff located in the NYS service center to include participation in initial orientation and at least annual training on NYS specific benefits, protocols and initiatives including:

   i. The Medicaid BH service array and associated medical necessity criteria with inter-rater reliability testing.

   ii. Network transformation initiatives.

   iii. Special populations.

I. **HARP requirements**: In addition to the personnel and notification requirements listed above, the HARP leadership team must include individuals with prior experience overseeing BH managed care or clinical programs. HARP leadership must include staff with extensive familiarity with or experience managing programs that provide or coordinate HCBS services in NYS and incorporate the values outlined in Section 1.1 (Vision) of this RFQ.

J. **HARP key personnel**: HARPs must designate one of the following key personnel as having overall accountability for the HARP product line. This position must be reflected in the Plan's organizational chart and the identified individual must have appropriate managerial experience.

   i. **Behavioral Health Medical Director**: The HARP Behavioral Health Medical Director shall hold a NYS license as a physician and should have a minimum of 5 years BH managed care or clinical experience in both psychiatry and addiction disorders. Plans offering HARP product lines must have a BH Medical Director for their qualified mainstream product lines as well as a HARP Behavioral Health Medical Director. One of these physicians must be boarded in general psychiatry and the other must have addiction certification.

   The Plan must describe how these Medical Directors will work jointly to effectively oversee BH services in both product lines. The HARP Medical Director and BH Medical Director(s) will have responsibility for the effective implementation of all clinical-medical programs in compliance with federal and State laws and the requirements set forth in this contract, including all documents incorporated by reference. The HARP Medical Director and Qualified Mainstream Plan Medical Director(s) shall be involved in the following functions related to eligible members under this HARP:

   a. Development, implementation, and interpretation of clinical-medical policies and procedures.

   b. Ensuring strong collaboration and coordination between physical and behavioral health care.

c. Clinical peer reviewer recruitment and supervision.

d. Provider recruitment, education, in-service training, and orientation.

e. Decision-making process for provider credentialing decisions.

f. Provider profile design and interpretation.

g. Development and implementation of the QM/UM Plan, including serving as the chairperson of QM/UM and peer review committees. Subcommittee participation may be delegated to medical director and/or associate medical directors.

h. Administration of all UM/QM and performance improvement activities, including grievances and appeals.

i. Attendance at regular (at least quarterly) medical director meetings designated by the State BH contract manager.

j. Attendance at Regional Planning Consortium meetings by one or both Medical Directors.

ii. **HARP Medical Director, General Medicine**: The HARP Medical Director, General Medicine, shall be responsible for oversight of integrated general medicine and behavioral health services, including a focus on pharmacy benefits and health risks of psychotropic drugs. The HARP Medical Director, General Medicine, shall hold a NYS license as a physician and should be board certified in general medicine or family practice. A minimum of 5 years of experience is required in a clinical or managed care setting (at least 2 of which are in a clinical setting). The Plan must note and provide a rationale for the full time equivalent (FTE) % effort dedicated to this role. The Plan can propose that an appropriately qualified physician fill both the HARP General Medicine and Behavioral Health Medical Director roles.

iii. **HARP Clinical Director**: The HARP Clinical Director shall be responsible for managing all HARP contract requirements in compliance with federal and State laws and the requirements set forth in the RFQ including all documents incorporated by reference. The HARP Clinical Director shall be a NYS licensed BHP with at least 7 years of experience in the management of BH services in organizations of similar size and responsibility to the requirements under the RFQ, including at least 2 years of managed care experience (preferably Medicaid managed care). The HARP Clinical Director could serve as the BH Clinical Director for smaller plans, pending review and approval by the State. This position shall be located in NYS and be solely dedicated to oversight of the HARP (and Qualified Mainstream Plan BH when approved) product line(s).

K. **Additional HARP Staffing Requirements:**

i. **HCBS Administrator:** Plans with a HARP product line shall have a HARP HCBS Administrator, who shall have knowledge of HCBS (see Table 2) and familiarity with HCBS regulatory requirements. This individual shall be responsible for ensuring that the Plan has appropriate processes in place for ensuring timely completion of needs

assessments, developing plans of care, determining necessity for ongoing services, and monitoring progress of individuals receiving HCBS. The ideal candidate should have at least three years' experience delivering or managing services for individuals with serious mental illness, serious SUD, and co-occurring SUD and SMI. The HARP HCBS Administrator ideally has experience working in a NYS behavioral health setting that provides recovery-oriented services to individuals with serious mental illness or serious substance use disorders (e.g., Personalized Recovery Oriented Services, peer services, housing supports, and supported employment). The Plan must note and provide a rationale for the FTE % effort dedicated to this role, and this position must work at sites located in NYS. This individual is solely dedicated to the HARP product line.

ii. **HARP Addictions Administrator**: Plans with a HARP product line shall have a HARP Addictions Administrator, who shall meet the requirements for a Credentialed Alcoholism and Substance Abuse Counselor (CASAC) in good standing with OASAS and have at least three years of experience in behavioral health 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. The ideal candidate should have experience with delivering or managing research-based and EBP for adults in clinical and/or recovery oriented settings. The Plan must note and provide a rationale for the FTE % effort dedicated to this role, and this position must work at sites located in NYS. This individual's responsibilities may span across the BH MCO and HARP product lines.

iii. **HARP utilization/care managers**: HARP utilization/care managers shall have experience and knowledge with BH rehabilitation programs, supported housing, supported employment, vocational rehabilitation resources, and welfare to work programs. Experience should include knowledge of recovery-oriented practices and development of EBPs as recognized by the SAMHSA and other national registries for these populations. Among other topics, training will be required in HCBS requirements, supportive housing and services for individuals with FEP.

Alternative Staffing Arrangements for HARPs: Plans wishing to be HARPS may propose ways to leverage the BH staffing requirements for mainstream Plans and HARPs to maximize their cost effectiveness and value. Proposals must contain specific details on how the functions will be assigned to assure sufficient dedicated resources are available for both HARP populations and individuals in mainstream Plans and how the Plan will ensure effective networks are developed and managed and services are provided to people with serious behavioral health conditions.

3.4 Member Services

A. The Plan shall expand its call center operations to respond to BH inquiries and to conduct triage to BH services 7 days per week. The Plan shall staff its call center with a sufficient number of trained member service representatives to answer the phones within telephone response standards defined in the MCO Model Contract. The Plan shall provide member service staff with access to appropriately qualified clinicians to assist with triaging callers who may be in crisis.

B. The Plan shall revise its member service policies and procedures to address the following:
   i. Information on the expanded array of Medicaid covered BH benefits and services, including where and how to access them;
   ii. Authorization requirements for BH services;
   iii. Requirements for responding promptly to family members and for supporting linkages to other member-serving systems including, but not limited to law enforcement, the criminal justice system, social services, OPWDD, and State or federally funded non-Medicaid BH services;
   iv. Protocols for assisting and triaging callers who may be in crisis by accessing a qualified clinician to take the call without placing the caller on hold. The qualified clinician shall assess the crisis and shall warm transfer the call to the crisis provider, call 911, refer the individual for services, refer the caller to his or her provider, or resolve the crisis over the telephone as appropriate.

C. The Plan shall revise the member handbook to include information on the expanded array of Medicaid BH benefits and services, including where and how to access them and related authorization requirements.
   i. Plans will distribute the revised member handbook to all enrollees.
   ii. Member handbooks shall clearly delineate the core benefits and the HARP enhanced benefit package. It should clearly identify the HARP eligibility requirements and the HARP application process.
   iii. The Plan shall train all existing and any new member service representatives on the revised policies and procedures. The revision and training shall incorporate NYS' vision, mission, and system goals and operating principles for BH managed care programs and services.

D. The Plan shall submit its member services and member handbook 90 days before implementation.

3.5 Network Service Requirements

A. The Plan's network service area shall consist of the county(ies) described in the Plan's current Medicaid managed care contract with NYS. Such service area is the specific geographic area within which eligible persons must reside to enroll in the MCO/HARP.

B. Members may choose the provider they prefer from a list of Plan contracted providers.

C. In establishing the network, the Contractor must consider the following:
   i. Anticipated enrollment;
   ii. Expected utilization of services by the population to be enrolled;
   iii. The number and types of providers necessary to furnish the services in the benefit package;
   iv. The number of providers who are not accepting new patients;
   v. The geographic location of the providers and enrollees.

D. In addition to the requirements in Section 21 of the MCO model contract, the Plan shall:

i. Develop a BH network based on the anticipated needs of special populations, including but not limited to:
   a. Transition age youth with behavioral health needs;
   b. Adults and transition age youth identified with First Episode Psychosis;
   c. High risk groups such as individuals with SMI, co-occurring major mental disorders and SUDs and those involved in multiple services systems (education, justice, medical, welfare, and child welfare);
   d. Individuals with I/DD in need of BH services;
   e. Individuals with a MH condition or a SUD and co-occurring chronic physical health conditions;
   f. Individuals with a SUD in need of medication-assisted treatment, including methadone and buprenorphine for opioid dependence;
   g. Homeless individuals;
   h. Individuals in Supportive Housing or other types of community housing;
   i. Adults transitioning from State Operated Psychiatric facilities and other inpatient and residential settings.

E. To be considered accessible, the network must contain a sufficient number and array of providers to meet the diverse needs of the member population. This includes:
   i. Being geographically accessible (meeting time/distance standards), culturally competent, and being physically accessible for people with disabilities;
   ii. Providing BH services for members in their entire service area;
   iii. Ensuring a sufficient number of providers in the network to assure accessibility to benefit package services using either New York State Office of Mental Health (OMH) and Office of Alcohol and Substance Abuse Services (OASAS) licensed programs and clinics and/or individual, appropriately licensed practitioners.

F. Minimum network standards for each service type are shown in Table 3. Plans must meet the network requirements in Section 3.5 as well as the requirements in Section 3.6. If contracting with required providers does not meet the minimum network standards, the Plan must contract with additional providers to meet the standard. After the 24 month period specified in Section 3.6 has passed, plans must continue to meet the standards established in Section 3.5 of this RFQ.

Table 3. Minimum Network Standards by Service Type

Service	Urban Counties	Rural Counties
OMH		
Outpatient Clinic	The higher of 50% of all licensed clinics or minimum of 2 per county	The higher of 50% of all licensed clinics or minimum of 2 per county
State Operated Outpatient Programs	All in county	All in region
PROS, IPRT or Continuing Day Treatment[9]	2 per county	2 per region
ACT	2 per county	2 per region
Partial Hospitalization	2 per county	2 per region
Inpatient Psychiatric Services	2 per county	2 per region
1915i-like HCBS services (HARPs only)[10]	2 of each service type per county (as available)	2 of each service type per region (as available)
Comprehensive Psychiatric Emergency Program & 9.39 ERs	2 per county	2 per region
OASAS		
Opioid Treatment Programs	All per county For NYC – all in the City	All per region
Inpatient Treatment	2 per county	2 per region
Detoxification (including Inpatient Hospital Detoxification, Inpatient Medically Supervised Detoxification, and Medically Supervised Outpatient Withdrawal	2 per county	2 per region
Outpatient Clinic	The higher of 50% of all licensed clinics or minimum of 2 per county	The higher of 50% of all licensed clinics or minimum of 2 per county
Rehabilitation services for residential SUD treatment supports	2 per county	2 per region
Buprenorphine prescribers	All licensed prescribers serving Medicaid patients	All licensed prescribers serving Medicaid patients
OMH and OASAS		

[9] PROS contracts should be at least two per county/region. In counties/region without two PROS programs, IPRT or CDT can be substituted for one.

[10] Services being developed.

Service	Urban Counties	Rural Counties
Health Homes (ROS)	2 per county (where available)	2 per region (where available)
Health Homes (NYC/ Long Island)	Higher standards to be developed	n/a

G. The Contractor shall comply with the appointment availability standards and definitions in the model contract. These are general standards and are not intended to supersede sound clinical judgment as to the necessity for care and services on a more expedient basis, when judged clinically necessary and appropriate. Table 4 illustrates how appointment availability standards will apply to each BH service type.

Table 4. Appointment Availability Standard by BH Service Type

Service Type	Emergency	Urgent	Non-urgent MH/SUD	BH Specialist	Follow-up to emergency or hospital discharge
MH Outpatient Clinic/PROS Clinic		Within 24 hrs	Within 1 wk		Within 5 days of request
ACT		Within 24 hrs for AOT		n/a	Within 5 days of request
PROS			Within 2 wks		Within 5 days of request
Continuing Day Treatment				2-4 wks	
IPRT				2-4 wks	
Partial Hospitalization					Within 5 days of request
Inpatient Psychiatric Services	Upon presentation				
CPEP	Upon presentation				
OASAS Outpatient Clinic		Within 24 hrs	Within 1 wk of request		Within 5 days of request
Detoxification	Upon presentation				
SUD Inpatient Rehab	Upon presentation	Within 24 hrs			
Opioid Treatment Program		Within 24 hrs			Within 5 days of request
Rehabilitation services for residential SUD treatment supports				2-4 wks	Within 5 days of request
1915(i)-like Home and Community Based Services					

Service Type	Emergency	Urgent	Non-urgent MH/SUD	BH Specialist	Follow-up to emergency or hospital discharge
Rehabilitation and Habilitation	n/a	n/a	Within 2 weeks of request		Within 5 days
Crisis Intervention/Respite	Immediately	Within 24 hours for short term respite	n/a		Immediate
Educational and Employment Support Services	n/a	n/a	Within 2 weeks of request		n/a
Peer Supports	n/a	Within 24 hours for symptom management	Within 1 week of request		Within 5 days

H. **Additional HARP Network Requirements**:

i. A Plan's HARP must cover all counties that their mainstream MCO Plan operates in.

ii. The HARP's network shall consist of the full range of physical health providers available through its mainstream Plan.

iii. The HARP will ensure an adequate network of Home and Community Based Services with a choice of qualified providers.

iv. The HARP shall develop and manage a continuum of supported education/employment services to assist members, including members with FEP and Transition Age Youth, to achieve their employment/education goals.

3.6 Network Contracting Requirements

A. The Plan will be required to contract with BH agencies licensed or certified by OMH or OASAS who currently serve five or more Medicaid managed care enrolled beneficiaries. MCOs/HARPs must contract with these current behavioral health agencies for at least the first 24 months of operation so long as quality of care is monitored and maintained consistent with 42 CFR 438.230(b)(4) and OASAS or OMH regulations.

B. The Plan will be required to contract with and maintain contracts with NY State determined essential community BH providers (at this time these include State operated behavioral health programs) so long as quality of care is monitored and maintained consistent with 42 CFR 438.230(b)(4).

C. The Plan will be required to contract with all Opioid Treatment programs in their service area (see Table 3) to ensure regional access and patient choice where possible so long as quality of care is monitored and maintained consistent with 42 CFR 438.230(b)(4).

D. The Plan will be required to contract with OASAS residential programs and pay their allied clinical service providers on a single case or contracted basis for members who are placed

in an OASAS certified residential programs to ensure continuity of care for patients placed outside of the MCO/ HARP's service area.

E. The Plan will be required to contract with an adequate number of behavioral health clinic providers that offer urgent and non-urgent same day services.

F. The Plan will be required to contract with crisis service providers and require that they respond to referrals 24 hours per day, 7 days per week, 365 days per year, as of the contract start date. Plans will monitor the performance of crisis providers, including tracking and reporting response time, utilization and cost by provider and opportunities for diversion or step down to lower levels of care that were delayed or missed due to the need for community-based alternatives.

G. Additional HARP Requirements

i. All HARP enrollees will be enrolled in Health Homes and the Health Home will serve as the care manager for all services including the home and community based services provided under the 1915(i)-like authority. If an eligible individual does not have a selected Health Home, the HARP will work with the individual to select a Health Home.

ii. HARP enrollees will not be required to change Health Homes at the time of the transition. After the 2 year transition period, HARPs will be required to contract as indicated in Table 3.

iii. HARPs will be required to pay on a single case basis for individuals enrolled in a Health Home at the time of transition when the Health Home is not under contract with the HARP.

3.7 Network Monitoring Requirements

A. Plans must conduct geographic access analyses per the standards in Section 15.5.c of the MCO Model Contract specific to each BH category of service listed in Tables 1 and 2 of this RFQ and/or as updated through future amendments to the State Plan or 1115 Demonstration. Travel time/distance to specialty care, hospitals, and behavioral health providers shall not exceed thirty (30) minutes/thirty (30) miles from the member's residence. Transport time and distance in rural areas to specialty care, hospitals, and mental health providers may be greater than thirty (30) minutes/thirty (30) miles from the member's residence if based on the community standard for accessing care or if by member's choice.

B. Plans must submit a detailed network plan for review that includes a listing of providers and explanation of network adequacy and approval as part of the required implementation plan outlined in Section 3.18 of this RFQ at least 120 days prior to the start-up date. The Plan shall include the following components:

i. Strategies to ensure uninterrupted services to members and that major components of the current network delivery system are not adversely affected by the transition to managed care.

ii. An orderly and timely process for the transition of the current network from FFS to managed care. This will include:

a. Establishing contracts at Medicaid fee-for-service rates for a minimum of two years with any OMH or OASAS licensed or certified provider with five or more active Plan members in treatment according to a list determined by NYS.

b. Plans must guarantee payment at FFS rates for continuous ongoing episodes of care, up to 24 months, for medically necessary services provided to Plan members by any OMH or OASAS licensed or certified provider regardless of their contract status. Plans may use acceptable UM protocols to review duration and intensity of this episode of care.

c. For continuity of care purposes Plans must allow members to continue with their care provider for the current episode of care. Plans may use acceptable UM protocols to review duration and intensity of this episode of care. This requirement will be in place for the first 24 months of the contract. It applies only to episodes of care that were ongoing during the transition period from FFS to managed care.

C. Plans shall submit to the State an Annual BH Network Plan to address unmet needs by 12 months after the implementation date and then annually thereafter. The Plan that contains specific action steps and measurable outcomes that are aligned with system goals and operating principles outlined in this Contract.

i. The Annual Network Plan shall include an analysis of Behavioral Health network adequacy that shall be derived from data on enrollment, utilization, prevalent diagnoses, member demographics, appointment availability, geographic access, out-of-network utilization (i.e., single case agreements), outcomes (when available), grievances, appeals, BH member satisfaction, and provider issues that were significant or required corrective action during the prior year.

ii. The Annual Network Plan will identify any current material gaps in the BH network, priorities for network development for the following year and a work plan with goals, action steps, timelines, performance targets, and measurement methodologies for addressing the gaps and priorities.

iii. The Annual Network Plan will be developed with the participation of consumers, family members/caretakers, providers (including State-operated providers), LGUs and other community stakeholders and be guided by the input of RPCs.

iv. The Plan's work plan shall be submitted to the State for approval. The Plan shall submit quarterly progress reports as requested by the State.

D. Plans shall submit the required documentation documenting adequate capacity and services, as specified by the State in this RFQ, as often as necessary but no less frequently than:

i. By the implementation date for the work pursuant to this RFQ.

ii. At any time there is a significant change in the Plan's operations that would affect adequate capacity for BH services and supports.

iii. Any time there are changes in services, benefits, geographic service area, or payments.

iv. At any time there is enrollment of a new population under the Contract.

E. Plans shall submit electronically to the Health Commerce System (HCS) an updated provider network report on a quarterly basis. The Plan shall submit an annual notarized attestation that the providers listed in each submission have executed an agreement with the Plan to serve Plan's HARP or MCO members as applicable. The report submission must comply with the Managed Care Provider Network Data Dictionary. Networks must be reported separately for each county in which the Plan operates and separately for HARPs. The Plan shall prepare the network inventory, including licensure, to quantify the number of network providers. At the request of the State, the Plan shall also provide an inventory of BH services for specific special populations identified in Section 3.5 D of this RFQ.

F. Plans shall maintain a database of providers that tracks clinical specialty or other areas of expertise, skills, and training consistent with the system goals and operating principles outlined in this RFQ. The database shall be available online to providers, consumers, family members, other community stakeholders, and Plan staff to conduct provider searches based on geographic, clinical specialty, and provider discipline search criteria.

G. Plans shall update and maintain the Plan's provider manual to include all relevant information on BH services and BH-specific provider requirements that are being added through this RFQ.

H. Plans shall credential OMH and OASAS licensed or certified programs. Plans contracting with OMH or OASAS licensed or certified programs may not separately credential individual staff members in their capacity as employees of these programs.

I. **Additional HARP Network Requirements**:

i. Special procedures for HCBS provider credentialing will be developed by the State in consultation with the Plans to ensure credentialing consistent with the approved HCBS provider qualifications. The Plans credentialing committee shall adhere to these procedures.

ii. The HARP, in coordination with the RPC, will conduct a HCBS needs assessment to identify unmet service needs in its service delivery system within nine months after the start-up date. The Plan shall submit a plan to the State to meet the unmet service needs as part of its required Annual Network Plan within 12 months after the contract start date.

iii. The HARP shall develop and submit to NYS for approval a separate HCBS provider manual (for inclusion in the MCO provider manual) that includes HCBS operational policies and procedures consistent with federal waiver requirements and relevant State policies and procedures.

iv. The HARP shall develop Health Home and provider profiling system that includes outcomes and compliance with HCBS assurances and sub-assurances.

v. The HARP shall comply with all federally funded and State funded housing requirements as directed by OMH/OASAS.

v. The Plan shall support the State in building capacity in Health Homes for management and care of individuals with a) SMI or b) a co-occurring MH disorder and SUD or c) either

a MH disorder or SUD and one other chronic medical condition or at risk of a chronic medical condition. Requirements include:

a. Performing network analyses to identify the practices/locations best suited for managing individuals with SMI or functionally limiting SUD.
b. Developing a process for identifying, assigning and tracking high risk members, based on clinical risk management standards, to an appropriate Health Home for engagement in Health Home services.
c. Promoting integrated care through Health Home, provider and member education, use of electronic records, decision support tools, consumer registries, data sharing, care coordination, and prevention-oriented interventions.
d. Establishing standard reporting measures on cost and quality that tie BH and medical financial, clinical and member satisfaction outcomes together.

3.8 Network Training

A. Plans will develop and implement a comprehensive provider training and support program for network providers to gain appropriate knowledge, skills, and expertise and receive technical assistance to comply with the requirements under managed care. To the extent practical, provider training should be coordinated through the RPCs.

B. The training program shall meet the following minimum requirements:

i. An annual training plan shall be developed that addresses all training requirements. The training shall be accessible to all network providers at alternate times and days of the week with sufficient opportunities to available to reach all providers. A schedule of training shall be available on the Plan's website and updated as needed but at least annually.
ii. Members and family members shall be included in the development and delivery of trainings.
iii. A cultural competency component shall be included in each provider training topic.
iv. An initial orientation and training shall be provided for all BH providers new to the Plan's network, including OMH licensed and OASAS certified providers.
v. Training and technical assistance shall be provided to BH network providers on billing, coding, data interface, documentation requirements, and UM requirements.
vi. BH network providers shall be informed in writing regarding the information requirements for UM decision making, procedure coding and submitting claims.
vii. BH network providers shall be educated and encouraged to use evidence-based and promising practices and to incorporate recovery principles into their service provision as well as into their policies and procedures.
viii. Contracted primary care providers and Health Homes shall be offered training on
    a. The BH service array available to Medicaid beneficiaries;
    b. Screening, Brief Intervention, Referral and Treatment;
    c. Screening for depression in primary care settings;

d. Identification of individuals with FEP and referral to appropriate FEP services. Plans will provide training and technical assistance on meeting the needs of individuals with FEP in conjunction with an entity designated by NYS;

e. The application of clinical practice guidelines and EBPs for BH conditions commonly treated in primary care settings.

ix. BH and medical providers shall be offered training on addressing co-occurring conditions, such as behavioral health and physical health and behavioral health and intellectual and developmental disabilities.

x. Plans will offer continuing medical education and continuing education unit credits to its network providers who complete attendance requirements for contractually required training.

C. Plans will provide technical assistance in other areas such as claim submission as indicated by provider performance identified through the Plan's QM and provider profiling programs. Plans will ensure providers receive prompt resolution to their problems.

D. Additional HARP Network Requirements:

a. The HARP shall offer training to all BH providers regarding HCBS requirements.

b. The HARP shall offer training and technical assistance to develop primary care provider capacity to successfully engage and work with individuals with SMI and functionally limiting SUD.

c. The HARP shall offer training to all contracted providers regarding common medical conditions and medical challenges in working with individuals with SMI and functionally limiting SUD.

3.9 Utilization Management

A. The Plan shall establish prior authorization and concurrent review protocols that comport with NYS Medicaid medical necessity standards, federal and State parity requirements, and other related standards that may be developed by OASAS and OMH, for the services listed on tables 1 and 2.

B. Plans that choose not to do prior authorization or concurrent review for specific ambulatory levels of care may need to provide NYS with their data–driven plan to identify and work with providers who are outside the norm regarding national standards of care and service utilization.

C. Plans establishing concurrent review protocols for Psychosocial Rehabilitation Services must consider the following factors:

i. Life goals – Services should target life goals such as educational; social; vocational; and self-maintenance;

ii. Person-directed services – Services should relate to individualized goals within a major life domain;

iii. Recovery focus – Services should incorporate a recovery focus, e.g.: "A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential," (from SAMHSA Definition of Recovery, 02/12);

iv. Admission criteria - Admission eligibility criteria should not restrict access to only individuals who have active symptoms. Individuals with functional impairments that substantially interfere with or limit one or more major life activities are eligible for these services;

v. Utilization of rehabilitation services and supports - As enrollees achieve recovery goals, the Plan shall ensure that person-centered planning focuses on titrating services to individualized needs so that improvements in functional impairments can be maintained when there is a reasonable expectation that withdrawal or premature reduction of services may result in loss of rehabilitation gains or goals attained by the enrollee. The person-centered planning process should also include approaches that assist the enrollee with achieving recovery to the fullest extent possible without unnecessary reliance on services and supports; and

vi. Need for off-site services - Plans shall ensure that mobile psychosocial rehabilitation services are available to promote recovery in the community where enrollees live and work, as well as promote access to community services.

D. In the event BH services are added to the Medicaid State Plan or utilization of BH services significantly deviates from expected levels or national norms, the Plan shall modify prior authorization and concurrent review requirements to appropriately manage utilization and cost in consultation with the State.

E. The Plan shall develop and implement BH-specific UM protocols, including policies and procedures (P&Ps) and level of care guidelines that comply with the following requirements:

i. UM protocols and level of care guidelines shall be specific to NYS levels of care and consistent with the State's medical necessity criteria and guidance.

ii. OASAS will identify the LOC guidelines that all Plans must use for SUD services. The LOCADTR tool will be used for making prior authorization and continuing care decisions for all SUD services.

iii. UM protocols and guidelines as well as any subsequent modifications to the protocols and guidelines shall be submitted to the State for prior review and approval.

iv. Level of care guidelines shall be developed and updated every year based on new evidence regarding emerging and promising practices and with the involvement of a physician who is board certified in general psychiatry, a physician who is certified in addiction medicine, and the OMH, OASAS and DOH medical and/or clinical director.

v. The Plan's UM system shall follow national and state standards and guidelines, promote quality of care, and adhere to standards of care, including protocols that address the following:

a. Review of clinical assessment information, treatment planning, concurrent review, and treatment progress to a) ensure the clinical appropriateness of care based on the consumer's current condition, effectiveness of previous treatment, environmental supports, and desired outcomes and b) to address gaps in care, including appropriate use of EBPs and issues of fidelity to practice guidelines and request changes to service plans to address unmet service needs that limit progress toward treatment and quality of life goals.

b. Promotion of recovery principles through the use of certified peer or family support services, natural supports, and other services that promote self-reliance including wellness recovery action plans.

c. Promotion of relapse/crisis prevention planning that goes beyond crisis intervention to include development and incorporation of advance directives in treatment planning and the provision of treatment for individuals with a history of frequent readmissions or crisis system utilization.

F. The Plan shall require that all admission and continued stay authorization decisions are made by a U.S. BHP with a minimum of three years of clinical experience in a BH setting.

G. The Plan shall ensure that decision makers on denials, grievances, and appeals meet the requirements in section 3.3 for clinical peer reviewers and have clinical expertise in treating the member's condition or disease, stratified by age, if any of the following apply:

i. An appeal of a denial based on lack of medical necessity.

ii. A grievance regarding the Plan denial of a request for an expedited resolution of an appeal.

iii. Any grievance or appeal involving clinical issues.

iv. An appeal of a decision to authorize a service in an amount, duration, or scope that is less than requested.

H. In general, denials, grievances, and appeals must be peer-to-peer — that is, the credential of the licensed clinician denying the care must be at least equal to that of the recommending clinician for any denials. In addition, the reviewer should have clinical experience relevant to the denial (for example, a denial of rehabilitation services must be made by a clinician with experience providing such service or at least in consultation with such a clinician, and a denial of specialized care for a child cannot be made by a geriatric specialist). In addition:

i. A physician board certified in general psychiatry must review all inpatient level of care denials for psychiatric treatment.

ii. A physician certified in addiction treatment must review all inpatient level of care denials for SUD treatment.

I. The Plan shall make available to the public, including all members and providers, the Plan's current UM protocols and level of care guidelines, including admission, continued stay, and discharge criteria.

J. The Plan shall educate UM staff in the application of UM protocols, clearly articulating the criteria to be used in making UM decisions and describing specific care management functions. The Plan shall demonstrate that all UM staff who are making service authorization decisions and/or conducting care management have been trained and are competent in working with the specific area of service for which they are authorizing and managing including, but not limited to co-occurring MH and SUDs, co-occurring BH and medical diagnoses, and co-occurring BH and I/DD.

K. The Plan shall ensure consistent application of review criteria regarding requests for initial and continuing stay authorizations. At a minimum, on an annual basis all staff performing initial and continuing stay authorizations and denial reviews shall participate in inter-rater

reliability testing to assess consistency in the application of level of care guidelines. Staff performing below acceptable thresholds for inter-rater reliability shall be retrained and monitored until performance exceeds the acceptable threshold. The inter-rater reliability testing, including test scenarios and processes, shall be customized to address all Medicaid BH services subject to prior authorization or concurrent review under the Contract, as defined in Section 3.9 of this RFQ. Results shall be reported the State annually.

L. The Plan shall establish criteria to identify quality issues, other than medical necessity, that result in referral to BH clinical peer reviewer for review and consultation. The Plan will develop a reasonable method, including automated online flags and UM documentation audits, for confirming that criteria are consistently applied during the UM process.

M. The Plan shall establish protocols for addressing discharge planning during initial and continued stay reviews. Protocols shall include, but are not limited to:

   i. Identifying comprehensive discharge plans that address not only treatment availability, but also community supports necessary for recovery including, but not limited to housing, financial support, medical care, transportation, employment and/or educational concerns, social supports, and a crisis prevention/wellness recovery action Plan;

   ii. Identifying and reducing barriers to access to and/or engagement with post-discharge ambulatory appointments, medication, and other treatment(s);

   iii. Confirming post-discharge appointment availability and adherence and in the absence of adherence, offering appointment options; and

   iv. Timeframes for each of the above.

N. The Plan shall comply with NYS Medicaid guidance including managed care policy documents, relevant performance improvement specification documents or manuals and policies governing prior authorization, concurrent or retrospective review. Specifically, Plans must incorporate the following into their guidance:

   i. OMH Clinic Standards of Care: (www.omh.ny.gov/omhweb/clinic_standards/care_anchors.html) and OASAS Clinical Guidance (http://www.oasas.ny.gov/treatment/documents/ClinicalGuidance-Final.pdf)

O. The Plan shall utilize information acquired through QM/UM activities to make annual recommendations to the State on the continuation or adoption of different practice guidelines and protocols, including measures of compliance, fidelity, and outcomes. The identification of evidence-based or promising practices shall consider cultural appropriateness. The Plan shall comply with the MCO Model Contract, Section 16.2, in implementing practice guidelines.

P. **In addition to the above UM requirements, HARPs must also meet the following additional requirements:**

   i. The HARP shall develop a data driven approach to identify service utilization patterns that deviate from any approved HCBS plan of care and conduct outreach to review such deviations and require appropriate adjustments to either service delivery or the plan of care.

ii. Prior authorization of all 1915(i)-like services is required to determine medical necessity and shall be based on a review of all functional assessments and proposed plans of care.

iii. Implementation of psychiatric advance directives consistent with the MCO Model Contract item 13.7.a.

3.10 Clinical Management

A. The Plan will implement a primary care screening and follow-up program for depression, anxiety disorders, and substance use disorders within six months after implementation and for the duration of the contract. This program shall include such follow-up methods as "collaborative care". Additionally:

i. The Plan shall disseminate clinical practice guidelines to contracted primary care providers regarding EBPs for BH conditions that are commonly treated in primary care settings. The Plan shall comply with the MCO Model Contract, Section 16.2, in implementing practice guidelines.

ii. The Plan shall establish a process for screening individuals in high-risk medical populations for BH conditions and/or psychosocial stressors that may impact their medical condition or adherence to related treatment regimens. Unless the individual refuses such assistance, the Qualified Mainstream Plan shall ensure an assessment is completed to identify BH service needs and expedite referral to the appropriate services.

B. The Plan shall meet the following BH-medical integration requirements within six months after implementation and for the duration of the contract:

iii. The Plan shall deliver orientation and ongoing training to educate its BH and medical staff about co-occurring BH and medical disorders, and integrated care management principles. The training objective is to strengthen the knowledge, skill, expertise, and coordination efforts within the respective outreach, UM, care management, pharmacy, and provider relations workforce.

iv. The Plan shall implement programs to manage complex and high-cost, co-occurring BH and medical conditions that include the following elements:

a. Identification processes, including claims-based analyses and predictive modeling to identify high risk members;

b. Stratification of cases according to risk, severity, co-morbidity, and level of need for targeted outreach;

c. Outreach, engagement, and intervention strategies based on stratification;

d. Care coordination or linkage to Health Home care coordination as appropriate;

e. Appropriate referral and use of community supports;

f. Provider collaboration;

g. Individualized, person-centered care plans; and

h. Outcome monitoring and reporting at the individual and program level.

v. The Plan shall analyze ED encounters to identify inappropriate ED use by BH recipients and develop and implement strategies to reduce inappropriate use of the ED.

vi. The Plan shall establish business rules regarding screening, referral, and co-management of high risk individuals with both BH-medical conditions. The protocols shall include the following components:

   a. Processes to encourage sharing clinical information among providers, as needed, for coordinated care.

   b. Training and monitoring staff on compliance with the protocols.

   c. Tracking and reporting to NYS of high risk member identification, referral, and engagement rates.

vii. The Plan shall develop data exchange protocols prior to initiation of services with any subcontracted BH management entity. Protocols must support BH-medical coordination including sharing of claims and pharmacy data, care plans and advance directives necessary to coordinate service delivery, and care management for each member in accordance with applicable privacy laws, including HIPPA and 42 CFR Part 2.

viii. The Plan shall provide information systems resources to its care managers to ensure access to up-to-date medical information such as medications, services provided (claims), service plans and crisis plans for their assigned members. The Plan's care management P&Ps shall outline medication management and monitoring requirements, as well as documentation responsibilities by care managers.

C. The Plan shall have the capacity to create Behavioral Health clinical practice guidelines for the identification and appropriate referral of individuals as required and shall implement these guidelines in the settings where such individuals are most likely to present, including but not limited to contracted primary care providers, hospitals, and outpatient clinics.

D. The Plan shall include the BH medical director in the evaluation of BH medications and other emerging technologies for the treatment of BH conditions and related decisions.

E. The Plan shall have the capacity to develop and implement a defined pharmacy management program for BH drug classifications within 12 months of implementation. At a minimum, this capacity must include the following areas:

i. Specialized pharmacy management policies for BH, primary care provider (PCP), and other specialty provider types including but not limited to polypharmacy, metabolic and cardiovascular side effects of psychotropic medications.

ii. Availability of multiple drug classes for various BH conditions.

iii. Use of data to identify opportunities for intervention that address safety, gaps in care, utilization, and cost.

iv. Provider outreach strategies that include telephonic and in-person outreach to outlier prescribers by qualified personnel (pharmacists, physicians) including SUD providers who see patients with alcohol and opioid disorders where there are no claims for addiction medications.

v. Member outreach strategies (to be reviewed and approved by the OMH and OASAS) to promote medication adherence.

vi. Reports that include statistics on the impact of interventions on outcomes and/or cost by drug class.

J. Develop definitive strategies to promote BH-medical integration to include a monitoring mechanism to measure the effectiveness of its strategy. The results of such monitoring shall be reported to the State on an annual basis. Considerations include:

i. co-location of BH practitioners in primary care settings;

ii. co-location of primary care physicians in BH settings; or

iii. The availability of a primary care supervising physician to provide consultation on complex health issues for the psychiatrist, medical nurse practitioner, and/or nurse care manager.

K. In addition to the clinical management requirements above, HARPs shall meet the following additional requirements:

i. The enrollment of all HARP members in Health Homes will be facilitated by the HARP within 15 days.

ii. Plans will facilitate the assignment of HARP enrollees into appropriate levels of intensity of care management.

iii. For HARP enrollees, the HARP shall provide care coordination and care management services directly through Health Homes. The care coordinator shall assist the member with accessing medical and BH services, provide member education and coaching to facilitate adherence to recommended treatment, and monitor member outcomes. Nothing in this requirement shall be construed to limit, in any way, the member's right to refuse treatment.

iv. In the first six months after start-up, the HARP shall collaborate with the State and providers to develop a protocol for screening for unmet medical needs in HARP enrollees. The protocol shall include the following minimum components:

a. A State approved standardized health screen that checks for common co-morbid medical conditions in SMI or functionally limited SUD populations; identifies current medications and recent acute, ED and ambulatory service utilization; and assesses for adherence to recommended health screening and medical treatments. Providers should submit screening results to the Plan and member's Health Home within 14 days of initial contact with a member.

b. A requirement that enrollees screening positive for co-morbid medical conditions receive a provider referral and a follow-up contact from the member's Health Home within seven days to facilitate a referral to needed medical services or for members already in an established primary care relationship, to assess for adherence to recommended medical treatment.

v. The Plan shall incorporate the following elements into its approach to integrated health care delivery for HARP enrollees:

a. Integration and coordination of care management responsibilities with the member's assigned Health Home.
b. A treatment team with an identified single point of contact.
c. A treatment team that includes a psychiatrist or equivalent BH medical professional and an assigned primary care physician.
d. Whole-person oriented care.
e. Health education, nicotine replacement therapy and health promotion services including assistance and education regarding health risk-reduction and healthy lifestyle choices, screening and referral for tobacco cessation services, the Plan's nurse-line, maternity care programs and services for pregnant women, appropriate use of health care services, self-care, management of health conditions, and wellness coaching.

vi. The Plan shall adopt, disseminate, and implement the State selected clinical practice guidelines listed below as well as nationally recognized clinical practice guidelines, including other evidence-based and promising practices.
a. SAMHSA's ACT
b. SAMHSA's illness management and recovery
c. SAMHSA's integrated treatment for co-occurring disorders
d. SAMHSA's supported employment
e. SAMHSA's family psychoeducation
f. OMH FEP practice guidelines
g. Seeking Safety
h. Motivational Enhancement Therapy
i. Twelve- Step Facilitation
j. Cognitive Behavioral Therapy for SUD
k. Medication Assisted Recovery for SUD
l. Other SUD EBP as recognized by SAMHSA

Dissemination should be done in collaboration with the RPCs as appropriate.

3.11 Cross System Collaboration

A. The Plan shall meet quarterly, at a minimum, for planning, communication and collaboration on care coordination initiatives with New York State. In New York City, these meetings will include the New York City Department of Health and Mental Hygiene.

B. At a minimum, Plans will meet quarterly with the RPCs in their respective regions. RPCs will be comprised of each LGU in a region, and representatives of mental health and substance use disorder service providers, peers, families, health home leads and Plans etc… The RPC would work closely with State agencies to guide behavioral health policy in the region, problem solve regional service delivery challenges, and recommend priorities for reinvestment of Medicaid savings.

C. The Plan will need to sign an MOA with the RPC for purposes of:
   i. Data sharing;
   ii. Service system planning;
   iii. Facilitating Medicaid linkages with social services and criminal justice/courts;
   iv. Coordinating provider and community training;
   v. Ensuring support to primary care providers, ED, and local emergency management (fire, police) when BH emergent and urgent problems are encountered.

D. The Plan shall work with the State to ensure that Transition Age Youth are provided continuity of care without service disruptions or mandatory changes in service providers.

E. Within six months of the start-up date, the Plan shall reach agreement and develop written policies and procedures with OMH and OASAS for the coordination of care when an individual is served by the Plan and OMH or OASAS through other federal or state funded programs and services. The Plan shall facilitate a process to review the written protocols on an annual basis with system partners and update as needed. The collaboration agreement shall address, at a minimum:
   i. Mechanisms for resolving problems;
   ii. Information sharing;
   iii. Procedures to identify and address joint training needs.

F. Additional HARP requirements:
   i. The HARP shall collaborate with the Local Governmental Unit /Single Point of Access (SPOA), other community stakeholders, State agency partners, federal agencies, and other entities that manage access to housing to assist:
      a. Members who are homeless or otherwise in need of Supportive Housing in obtaining and maintaining housing through supportive services targeted to promote housing stability.
      b. OMH/OASAS with transitioning existing housing programs where services are integrated with the housing to a Supportive Housing model, where individuals can obtain supportive services tailored to their needs separately from their housing.

3.12 Quality Management

A. The MCO shall amend its quality assurance program as required in Section 16.1 of the MCO Model Contract to address BH-specific monitoring requirements outlined throughout this RFQ.

B. The MCO shall maintain an active BH QM sub-committee which shall include members, family members, peer specialists, provider representatives. It will be responsible for carrying out the planned activities of the BH QM program and be accountable to and report regularly to the governing board or its designee concerning BH QM activities. The Plan's BH QM administrator shall lead quarterly BH QM sub-committee meetings and maintain records documenting attendance by members, family members, and providers, as well as committee's findings, recommendations, and actions.

C. The MCO shall implement an active BH UM sub-committee that is chaired by the BH medical director and is charged with implementing a process to collect, monitor, analyze, evaluate, and report utilization data consistent with the reporting requirements defined in Section 3.13 of this RFQ. The BH UM sub-committee shall review and analyze the following data elements, interpret the variances, review outcomes, and develop and/or approve interventions based on the findings:
   i. Under and over utilization of BH services and cost data;
   ii. Readmission rates and the average length of stay for all psychiatric, SUD inpatient and residential levels of care facilities;
   iii. Inpatient and outpatient civil commitments;
   iv. Follow up after discharge from psychiatric, SUD inpatient and residential levels of care facilities;
   v. SUD initiation and engagement rates;
   vi. ED utilization and crisis services use;
   vii. BH prior authorization/denial and notices of action;
   viii. Psychotropic medication utilization;
   ix. Addiction medication utilization.

   The MCO shall ensure intervention strategies have measurable outcomes and are recorded in the UM/medical management (MM) committee meeting minutes.

D. The Plan shall develop and maintain mechanisms to:
   i. Monitor service quality and develop quality improvement initiatives.
   ii. Solicit feedback and recommendations from key stakeholders to improve quality of care and member outcomes.
   iii. At a minimum, these mechanisms shall include consumer and other stakeholder advisory boards and key stakeholders shall include members, family members, subcontracted Plans, and other member serving agencies.

E. **In addition to the QM requirements above, HARPs shall meet the following additional requirements:**
   i. The HARP shall have a quality assurance program that is separate and distinct from the mainstream MCO quality assurance program and that meets all of the requirements contained in this RFQ and Section 16 of the MCO Model Contract as well as all terms and conditions of the 1115 Partnership Plan relating to 1915(i)-like quality assurance performance measure reporting. This shall include a quality management committee as described in 3.12(B).
   ii. The HARP will establish a UM committee that shall address:
      c. Any UM committee requirements from the mainstream managed care requirements;
      d. Requirements in Section 3.12(C) above;
      e. Avoidable hospital admissions and readmission rates and the average length of stay for all psychiatric, SUD, residential levels of care, and medical inpatient facilities;

f. Follow up after discharge from inpatient care, and residential levels of care;
g. Prior authorization/denial and notices of action;
h. Pharmacy utilization including physical health, psychotropic and addiction medications;
i. 1915(i)-like HCBS service utilization;
j. HCBS quality assurance performance measure reporting;
k. All physical health measures required by the MCO model contract; and
l. Rates of initiation and engagement of individuals with FEP in services.

3.13 Reporting

A. The performance measurement approach will build from existing Quality Assurance Reporting Requirements (QARR) measures with the addition of HEDIS, HEDIS-like, and National Quality Forum measures based on claims and encounters.

B. The Plan shall prepare and submit the standard reports to the State as specified in the Behavioral Health Addendum to the Quality Assurance Reporting Requirements (QARR) (see Attachment A) within the timeframes listed in Section 18.2 of the MCO Model Contract. Performance measures shall be audited per the terms of the MCO Model Contract, Section18.5.v.

C. In addition to the requirements in Section 18.5.x of the MCO Model Contract, the Plan will participate in one New York State sponsored focused clinical study on select topics or initiatives affecting people with BH each year and conduct at least one additional internal performance improvement project (PIP) on a priority BH topic area of its choosing each year, with approval by the State. The focused study and PIP will meet the requirements of Section 18.5.x of the MCO Model Contract.

D. Plans may be required to conduct a transition survey to address member experience with the transition of behavioral health services to managed care.

E. The Plan will separately track, trend, and report BH complaints, grievances, and appeals.

F. **HARPs shall meet the following additional requirements:**

i. The HARP shall prepare and submit the standard reports to the State as specified in the BH Addendum to the Quality Assurance Reporting Requirements (QARR) (see Attachment B) within the timeframes listed in Section 18.2 of the MCO Model Contract. Performance measures shall be audited per the terms of the MCO Model Contract, Section18.5.v. Compliance with federal HCBS quality assurance performance measure reporting requirements will be required for persons receiving 1915(i)-like services consistent with the 1115 Standard Terms and Conditions.

ii. Reporting on new recovery outcome measures in areas such as employment, housing, criminal justice status, and functional status will be required. These social outcome measures will be based on the 1915(i)-like eligibility evaluation and consumer self-report.

iii. The HARP will conduct at least two additional New York State mandated clinical quality studies annually on select topics or initiatives affecting people with BH each year. These are in addition those required by Section 18.5.x of the MCO Model Contract.

iv. The HARP will conduct two additional internal PIP on a priority topic area of its choosing each year, with approval by the State. These are in addition to those required by Section 18.5.x of the MCO Model Contract. The PIP should be on a topic affecting people with BH.

v. The clinical quality studies and PIPs are separate from those done by the MCO and must meet the requirements of Section 18.5.x of the MCO Model Contract.

vi. The HARP will conduct performance improvement projects for any HCBS quality assurance performance measures if compliance falls below the CMS-required 86% compliance threshold.

vii. The HARP must conduct a one time member transition survey as well as an annual supplemental consumer perception survey.

F. The HARP shall track compliance with and report on compliance with:

i. HCBS assurances and sub-assurances; (see Attachment B);

ii. Protocols for expedited and standard appeals regarding eligibility determinations for the enhanced benefit and related services;

iii. Protocols for the identification and prompt referral of individuals with FEP to programs and services, preferentially referring such individuals to OMH designated FEP services to the extent such services are available within a reasonable distance.

3.14 Claims

iv. The Plan shall meet the requirements for claiming, including timely and accurate payment of claims, as specified in NYS law and required by DOH.

v. The Plan shall have an automated claim and encounter processing system that will support the requirements of this RFQ and ensure the accurate and timely processing of claims and encounters and allow the Plan to verify services actually provided. The Plan shall offer its providers an electronic payment option.

vi. The Plan shall support both hardcopy and electronic submission of claims and encounters for all claim types (hospital and professional services).

vii. The Plan must support hardcopy and electronic submission of claim inquiry forms, and adjustment claims and encounters.

viii. The Plan shall have a system to support additional BH services including additional provider types, and provider specialties not covered under the PH programs.

ix. The Plan shall have the capability to track and pay Health Homes to administer care coordination.

3.15 Information Systems and Website Capabilities

A. The Plan shall have information systems that enable the paperless submission of prior authorization and (if applicable) other UM related requests, and when applicable the

automated processing of said requests. These systems shall also provide status information on the processing of said requests. These shall be interfaced as needed to care coordination systems to facilitate care coordination across providers and systems and direction to appropriate services.

B. The Plan shall maintain BH content on a website that meets the following minimum requirements:
   i. Public and secure access via multi-level portals (such as providers and members) for providing web-based training, standard reporting, and data access as needed for the effective management and evaluation of the performance of the Plan and the service delivery system as described under this RFQ.
   ii. The Plan shall organize the website to allow for easy access of information by members, family members, network providers, stakeholders, and the general public in compliance with the Americans with Disabilities Act. The Plan shall include on its website, at a minimum, the following information or links:
      a. Hours of operations for the Plan.
      b. How to access services, including BH and crisis contact information, and toll-free crisis telephone numbers.
      c. Telecommunications device for the deaf/text telephone numbers.
      d. Information on the right to choose a qualified BH service provider.
      e. An overview of the new range of behavioral health services being provided. For HARPS, this should include descriptions of the new HCBS services and the process for accessing these services.
      f. A provider directory that includes BH provider names, locations, telephone numbers, service types, non-English languages spoken for current network providers in the member's service area, providers that are not accepting new patients and, including, at a minimum, information on specialists and hospitals. This directory should include a list of buprenorphine providers and methadone providers.
      g. Access to BH-medical integration tools and supports to support provider integration initiatives.
      h. Access to information for Transition Age Youth and members with FEP
      i. Member access to personalized self-service/self-help tools for co-occurring BH-medical conditions.
      j. A library, for providers and members, that provides comprehensive information and practical recommendations related to mental illness, addiction and recovery, life events, and daily living skills.
      k. The Plan's member handbook and provider manual.
      l. Information regarding community forums, volunteer activities, and workgroups/committees that provide opportunities for members receiving services, family members, providers, and stakeholders to become involved.

m. Information regarding advocacy organizations, including how members and other family members may access advocacy services.

n. Hyperlinks to the SDOH, OMH, OASAS and county/New York City mental hygiene department websites.

o. Opportunities, including surveys, for BH members, family members, network providers, and other stakeholders to provide satisfaction feedback.

p. Other documents as required by OMH, OASAS, or SDOH.

A. **Additional HARP requirements**.

i. HARPs shall have information systems for the collection of data elements for 1915(i)-like services such as assessment elements, plan of care elements, and amount, duration and scope of services.

ii. The Plan IT system (See Attachment E for details) will include functionality for all HCBS required reporting including level of care, plan of care, qualified provider, health and welfare, and fiscal accountability monitoring for the 1915(i)-like HCBS program for individuals in the HARP program. The application will provide the Plan management staff with the tools needed to perform all the Federal reporting required by the Home and Community Based Services Program under the 1115 demonstration amendment including:

a. The system should ensure that the HCBS programs have the following analytical capability to; calculate performance indicators; detect data redundancy; measure data quality; and document compliance with State and federal regulations.

b. The system should be flexible enough to accommodate the requirements as stated in the standard terms and conditions (STCs) and accommodate the normal changes that are identified through the quality improvement process.

c. The system will have at a minimum the capability to house assessment data and electronic versions of the Recovery Plan to serve as the prior authorization for any HCBS services in the Plan's claims management system.

d. The ability to create reports on any date, timely completion indicator, etc. for quality of care monitoring related to HCBS quality assurance measures.

3.16 Financial Management

A. The Plan shall adhere to the financial reporting and solvency requirements as outlined in the MCO Contract.

B. The Plan shall amend its financial reporting requirements as required in Section 18.5 a) i, ii and iii of the MCO Model Contract to address BH-specific medical and administrative expenditures outlined throughout this RFQ and as determined by the State. This includes, but is not limited to, separate reporting for all categories of aid for which a capitation rate is paid.

C. Payments made to the MCOs for adult Medicaid recipients for capitated services will require a minimum medical loss ratio.

i. The minimum medical loss ratio in MCOs will apply to BH services only.
ii. Medical loss will be determined as a percentage of the gross premium, less any withhold by the state for "stop loss" or other general "risk mitigation" pools, and in future years amounts reserved for quality incentives. The non-medical provisions of the premium include administration, profit, taxes (as applicable). Medical loss will be determined as a percentage of premiums, net of an allowance for administration, profit and taxes.
iii. The calculation methodology for verifying medical loss will be provided as part of the financial reporting templates and instructions prescribed by the State after contract award.
iv. If the Plan underspends relative to the required medical loss ratio, the difference will be rebated to NYS.
v. The State may choose to use any amount rebated to NYS to increase the capacity of existing BH services, support the new BH services under the approved 1115 demonstration and address inter-regional premium variances. The State may require that these rebates be held by the MCOs for the State in funds designated for these purposes. If the rebates are not utilized, the rebate will be refunded to the State and the federal share will be returned to CMS.

D. Plans may, subject to State review and approval, enter into shared savings or incentive payment arrangements with providers to incentivize access to and coordination of care and to provide improved outcomes resulting from the integration of BH and PH services.
   i. The calculation of medical loss ratio may be adapted to account for these arrangements. Any provider incentives shall be consistent with the limitations on physician incentives outlined in the MCO Model Contract Sections 18.11 and 22.14 consistent with 42 CFR 438.6(h).
   ii. Administrative expenses associated with any shared savings or incentive payment arrangements, including subcapitation, will not be considered medical expenses for purposes of calculating medical loss ratios.

E. Any incentives shall promote BH medical integration by addressing performance in one or more of the following areas:
   i. Submitting the screening results described Section 3.10 to the Plan.
   ii. Developing care coordination capacity for members with co-occurring chronic medical conditions and BH disorders.
   iii. Implementation of embedded/co-located primary care and Behavioral Health practitioners.
   iv. Meeting the primary care needs of individuals with serious mental disorders.
   v. Identification and referral of individuals with FEP.
   vi. Meeting specialized training or credentialing requirements.
   vii. Consultation and referrals to specialty care settings (onsite consultations for rapid care)).The Plan may implement alternate performance improvement targets to meet this Contract term upon review and approval of the State.

F. Risk Mitigation

i. New York State is considering modifying the current 30 day psychiatric stop loss provision. Over time, NYS wants to eliminate the unique provision for psychiatric care without creating incentives to shift risks to hospitals for patients who require extended stays for medical and other reasons. Options include a multi-year progression toward 100 days, with possible cost sharing on stays beyond 30 days, and then ultimately elimination. NYS will meet with stakeholders to develop a mutually acceptable methodology including provisions to prevent unjustified cost shifts to hospitals.

ii. New York State is simultaneously considering a total individual stop-loss with cost sharing at an amount to be determined.

G. Additional HARP requirements

i. The minimum medical loss ratio in HARPs will encompass both Behavioral Health and Physical Health.

3.17 Performance Incentives

A. For MCOs, the present structure for quality incentives will be maintained but with a greater emphasis on behavioral health performance metrics.

B. For HARPs, the present quality incentive program will be modified significantly and financed using a premium withhold to create a pool for creating quality incentives.

i. During year one there will be no withhold or quality incentive.

ii. During year two there will be up to a 1% withhold to pay a quality incentive based on year one metrics.

iii. During year three there will be up to a 1.5% withhold to pay a quality incentive based on year two metrics.

iv. During year four and each year thereafter the quality incentive program will continue at the year three rate or greater.

3.18 Implementation planning

A. Within five days of confirmation of qualification, the Plan must be available to meet with the State to work toward a successful implementation by January 1, 2015. At this meeting, the Plan shall:

i. Define the project management team, the communication paths, and reporting standards between the State and the Plan.

ii. Define expectations for content and format of Contract deliverables.

B. Within 30 days of confirmation of qualification, the Plan must submit a comprehensive written implementation Plan that addresses:

i. Key milestones for all tasks that are necessary to meet the requirements of this RFQ with timeframes for implementation including, but not limited to hiring, facilities, call center operations, network development, training, eligibility for enhanced benefits, UM, QM, care transitions, and ongoing clinical management, fiscal management, and information systems enhancements.

ii. A detailed description of implementation methods.

iii. Expectations of work to be performed by responsible party (e.g., the State, the Plan) and include:

a. A communication Plan that addresses how the Plan will communicate with consumers, family members, providers, stakeholders and the RPC.

b. For HARPS, a Plan for implementing data-driven and other strategies to monitor compliance with HCBS requirements for the 1915(1)-like component of the Demonstration Amendment, including evaluating the adequacy of plans of care and that services are implemented consistent with the plan of care.

c. An operational readiness Plan.

C. The Plan must develop an implementation team designed to ensure the implementation Plan progresses according to the required timelines.

D. The Plan must designate a full time implementation manager within one week of selection/designation. The manager shall have overall responsibility for successful completion of the Plan's implementation responsibilities.

E. The implementation manager and appropriate staff shall meet with and/or provide written status reports to the State at least weekly. The purpose of these meetings is for the Plan to communicate progress, identify issues, recommend courses of action, and obtain approval (if necessary) for making modifications to the implementation Plan. This status report must include:

i. An updated implementation plan and responsibility matrix.

ii. A list of tasks that are behind schedule.

iii. Issues requiring the State's attention, current status, and plans for resolution.

iv. Anticipated staffing changes requiring State approval.

F. The Plan shall be responsible for documenting all implementation meetings, with the State. Written minutes from all meetings are to be provided to the State no later than three business days after the date of the meeting.

G. No later than 60 days prior to the start-up, the Plan must demonstrate its readiness to provide the services identified in this RFQ during a readiness review. The Plan must cooperate fully with this review and develop and implement a corrective action Plan in response to deficiencies. The Plan can commence operations only if all corrective action requirements due on or before the effective date are met to the satisfaction of the State BH.

4.0 Request for Qualifications (RFQ)

Proposals shall be prepared using a font size of no less than 12 points on 8 ½ x 11 paper, single spaced, double-sided, subject to the required response format and any page limits specified in each individual question. For multi-part questions please organize responses accordingly (e.g., A.1, A.2.a, A.2.b, etc.). Include a table of contents and number all pages in a consistent manner. Proposal materials shall be organized into 3-ring binders with tab dividers corresponding headings A through L. Please also include a collated PDF file of the entire proposal on a USB flash drive.

For any question that pertains to a function that will not be delegated, the response should reflect only the experience and capability of the Plan. For any question that pertains to a function that will be delegated, the response may and should reflect the experience or capability of the organization to which that function will be delegated. On any item where "the responder" includes a delegated entity, clearly identify the role of the Plan as distinct from the role of any delegate(s) and the name of the delegate(s) within the response.

When a customer reference is requested on an individual question, provide the contact person's name, title, phone number, and email address.

All questions apply to The Plan as defined in Section 2.0 unless otherwise noted as a HARP only question. Response to HARP only questions should follow the same rules stated above. Plans requesting qualification as a HARP should complete the response for the mainstream MCO with a HARP addendum corresponding to each section below.

If you are proposing alternative experience or staffing arrangements as discussed in Section 3, please be sure to address the questions in ways that reflect this alternate experience or staffing.

Approved Plans must comply with all existing DOH contract requirements. While some questions below may duplicate existing Plan submission requirements, the information requested will be used in evaluating Plan qualifications to manage Behavioral Health services.

A. Organization, Experience, and Performance

1. Provide the following information regarding your Plan:
   a. Plan name.
   b. Plan State and federal tax identification numbers.
   c. Name, address, and phone number of principal officer.
   d. Name and address for purpose of issuing checks and/or drafts.
2. Identify any entity, including a parent, subsidiary, affiliate, or other related organization, with which the responder intends to delegate, through a partnership or subcontract, any administrative or management services required under the RFQ. Submit the following information regarding each proposed partner or subcontractor:
   a. Name, address, and telephone number of the organization.
   b. Ownership of the organization.
   c. Specific management service(s) that will be delegated.
   d. The number of years of the organization's relevant BH managed care experience.

e. The number of years the contractual relationship has been in place with this organization for comparable services.

f. The proposed compensation arrangement.

g. The responder's plan for obtaining the delegate's acceptance of all delegated Contract requirements.

h. The responder's plan and related monitoring protocols for conducting oversight of all delegated activities.

i. Two references for the delegate (including name, title, organization, address, telephone number, email address, scope of services provided to reference and time period that services were provided).

j. An attestation signed and dated by an officer of the delegate, that the organization, its employees and consultants have never been debarred, suspended, or excluded from any federal or State program.

k. Indicate whether the delegate organization or its key personnel have been arrested, charged with or convicted of a felony in the most recent five (5) calendar years. If yes, identify the key personnel or organization and describe the arrest, charges, or type of felony, and the outcome.

l. Indicate whether the delegate organization filed for bankruptcy in the most recent five (5) calendar years.

m. Provide a copy of the delegate organization's Business Continuity, Disaster Recovery and Emergency Response Plan. It does not need to be NYS specific, but it must address the requirements under the RFQ. The Plan must also address how the organization will participate in disaster recovery when a disaster occurs and a state of emergency is declared by the governor.

Page limit: five (5) pages per subcontractor or partnership arrangement, excluding the attestations.

3. Identify the year in which the responder first managed BH care services for government/public sector eligible members. Identify any year(s) in which the responder did not provide managed BH care services to government/public sector clients between that first year and 2013 and explain any gaps in service. Respond separately for the Plan and any relevant delegate(s).

   Page limit: one (1).

4. List the government/public sector customers for which the responder has managed the BH care services in the most recent three (10) calendar years. Provide the following information separately for each customer listed. Respond separately for the Plan and any relevant delegate(s). Please note on your response if alternate experience is being claimed as discussed in Section 3, and fill out the response accordingly.

   a. The customer name.

   b. The type of contract (i.e., BH carve-out vs. carve-in and name of health Plan).

   c. Brief summary of the services provided

d. The Medicaid populations served under the contract (e.g., Titles XIX, Title XXI).
e. The number of eligible Medicaid members, child, adult, and total.
f. The annual value of the contract for the most recent year the contract was active.
g. The geographic area covered under the contract (e.g., statewide, single county, urban, rural).
h. Whether the contract was non-risk, partial risk, or full risk.
i. List any administrative services that were delegated or administered by an organization other than the responder (i.e., claims administration).
j. Number of years the responder has held the contract.
k. If the contract is active or terminated, and if terminated, the termination date and the reason for the termination.

Page limit: one (1) page per customer.

5. Provide the total government/public sector managed BH care revenue and the percentage of the responder's managed BH care revenue attributed to government/public sector customers in calendar years 2011 and 2012 using the format provided below. Complete separate tables for the Plan and any relevant delegate. Complete a separate table for the Plan and any delegate(s). Please note on your response if alternate experience is being claimed as discussed in Section 3, and fill out the response accordingly.

Government/Public Sector Managed BH Revenue		
	CY 2012	CY 2013
Total Managed BH Revenue		
Government/Public Sector Managed BH Revenue		
% of Total Attributable to Government/Public Sector		

6. Indicate whether the responder had funds withheld and not released, funds recouped, or funds paid as a penalty related to performance guarantees under a managed BH care contract with a government/public sector customer in the most recent three (3) calendar years (i.e., penalties paid in 2011 through 2013 for performance in 2010 through 2012). For any alternate experience being claimed as discussed in Section 3, fill out the response accordingly.

   If yes, list each government/public sector customer(s) to whom penalties were paid and provide the following information:

   a. The date of the penalty.
   b. The penalty amount.
   c. The reason for each penalty.
   d. The actions taken to improve performance.

e. The time period elapsed to correct the deficiency that precipitated the penalty.

Page limit: one (1) page per customer.

7. Other than those reported in the prior item, indicate whether the responder has had any financial sanctions, corrective actions, notices to cure or other written notifications that the responder's performance for a public sector, managed BH care contract required correction in the most recent three (10) calendar years (i.e., sanctions paid in 2010 through 2013 for performance in 2010, through 2012). For any alternate experience being claimed in response to Section 3, fill out the response accordingly. If yes, list each government/public sector customer to whom sanctions were paid and provide the following information:
   a. The date of the sanction.
   b. The sanction amount.
   c. The reason for each sanction.
   d. The actions taken to improve performance.
   e. The time period elapsed to correct the deficiency that precipitated the sanction.

   Page limit: one (2) page per customer.
8. List the proposed location(s) to administer the required services under this RFQ. Identify all required services and administrative functions by location. Include any subcontractors or partnerships or administrative functions that will be performed all or in part (e.g., after hours, credentials verification, corporate legal) at other locations. Repeat the grid if multiple locations will be used.

   Service Center Location

   Name of Location _____

   City, State, Zip _____

   Type(s) of Service(s) _____

   Areas covered _____

   Date Operational _____

9. Indicate hours of operation for each service center proposed in A.8. Repeat the grid if multiple locations will be used.

Hours of Operation		
Day	**From**	**To**
Monday through Friday	am/pm	am/pm
Saturday/ Sunday/Holidays	am/pm	am/pm
Service Center Location		

10. Provide an organizational table that reflects your planned committee structure. Please describe how this structure will be used to meet the requirements under this RFQ, including stakeholder advisory, credentialing, QM, and UM committees as well as interfacing with LGUs and RPCs. Clearly delineate when a committee or sub-committee is BH-specific or integrated with medical.

    Page limit: one (1).

11. If the Plan is using subcontractors or other partnerships to perform key functions under this RFQ, provide for the following for the subcontractor or partner: contact information for three (3) current contracts and two (2) terminated (in the last three (3) years) contracts with government/public sector customers for whom the responder manages (managed) Medicaid BH care services. Use the tables below:

ACTIVE

	Customer 1	Customer 2	Customer 3
Name			
Address			
City, State, Zip			
Telephone Number			

TERMINATED

	Customer 1	Customer 2
Name		
Address		
City, State, Zip		
Telephone Number		

HARP Only Organization, Experience and Performance Questions

12. Provide an overview of the role of the HARP that reflects your understanding of the system goals, operating principles and desired outcomes outlined in the Section 1.3 of the RFQ related to serving members who meet targeting and functional criteria for 1915(i)-like benefits.

    Page limit: two (2).

13. Briefly describe innovative approaches to governance that achieve the goals and objectives described under system goals and operating principles described in Section 1.7. Include the governance structure, key attributes of the structure and nature of the participants as well as two outcomes that illustrate the value of this approach.

    Page limit: three (3).

B. Personnel

Plans wishing to be HARPS should respond to all questions in Section 4.0 B for both the Mainstream MCO BH component and the HARP product line. Plans not applying for a HARP do not need to respond to questions regarding HCBS services and compliance. In an addendum to this section, clearly address how the requirements of the HARP will be met.

1. Submit the responder's organizational charts that show:
   a. Departments and reporting structure for all key personnel, managerial staff and qualified supporting staff, including lines of responsibility and authority for all functions performing work under this RFQ. Key personnel and managerial staff positions should be individually reflected in the organizational chart while qualified supporting staff should be rolled up by functional area. Include all Plan positions, responsibilities and reporting relationships specific to RFQ requirements in each of the following functional areas:
      i. Customer/member services.
      ii. Utilization/care management.
      iii. Medical management.
      iv. Network development, management and provider relations.
      v. Training.
      vi. QM.
      vii. HCBS Compliance.
      viii. Information technology.
   b. Reflect which key personnel will have overall accountability for the Mainstream MCO BH product line.
   c. Reflect which key personnel will have overall accountability for the HARP product line.
   d. If any services will be delegated, reflect the primary individuals responsible for oversight of each delegated entity.
2. Provide the planned FTE for key personnel, managerial staff and supporting staff positions using the format provided in the following table. Supporting staff FTE should reflect those FTE that will be converted and/or added to meet the requirements under the RFQ, not existing staff dedicated to current functions under the current MCO Contract. If positions will be shared, allocate FTE based on projected time spent on MCO BH vs. HARP functions; there should be no overlap in FTE allocation across reporting cells in the Table.

Personnel Requirements				
Key Personnel	**MCO BH FTE**	**BH Dedicated?**	**HARP FTE**	**HARP Dedicated?**
BH Medical Director				
General Medical Director				
BH Clinical Director				

Managerial Staff			
Utilization/Care Management[11]			
Network Development			
Provider Relations			
Quality Management			
Training			
Information Systems			
Government Community Liaison			
Supporting Staff			
Member Services, Intake and Referral			
Crisis Intake and Referral			
Utilization/Care Management			
Clinical Peer Reviewers			
Network Development/Management			
Provider Relations			
QM Specialists			
Claims/Encounter Processing			
Grievance and Appeal			
Data Reporting Analysts			
Financial Reporting Analysts			
Other (add rows as necessary)			

3. Provide the following information regarding your organizational structure:
   a. For any key personnel or managerial staff positions that are less than fulltime as required in Section 3.3, provide the rationale.
   b. For any key personnel or managerial staff positions that are not dedicated as required in Section 3.3, provide the rationale.
   c. Describe the responder's proposed approach to coordination between the mainstream MCO and HARP medical directors.
   d. For any positions that are shared or combined or for any alternate staffing plans as allowed in Section 3.3, describe how staff roles delineated in the RFQ will be addressed.

[11] Including managers and supervisors

Page limit: two (2).

4. Submit current resumes of all known proposed key and managerial personnel, as defined in Section 3.3 of the RFQ, documenting their education, certifications/licensure, career history, and special skills or other qualifications. If proposed key or managerial personnel are not yet identified, submit job descriptions outlining a) the minimum qualifications of the position(s), including education, certifications/licensure, experience, special skills and b) responsibilities for the position. New York State reserves the right to disapprove key personnel based on character and competence.

   Page limit: three (3) pages per resume or job description.

5. Describe clinical peer reviewer resources by clinical specialty area and how these resources will be expanded to address increased responsibilities under the RFQ.

   Page limit: one (1).

6. Describe the responder's proposed committee structure, staffing and committee lines of accountability with a brief description of responsibility, including whether the committee includes stakeholder participation.

   Page limit: one (1).

7. Describe the human resources and staffing plan for ensuring the successful accomplishments of all duties outlined in the RFQ including the key personnel, required personnel, and other staff. Include a discussion of the responder's staff recruitment, orientation, and training plans.

   Page limit: four (4).

8. Plans wishing to be HARPS may propose ways to leverage the BH staffing requirements for mainstream Plans and HARPs to maximize their cost effectiveness and value. Provide an organizational chart and details on how the functions of key or required personnel will be assigned between the mainstream Plan and the HARP in ways that assure sufficient dedicated resources are available for both HARP populations and individuals in mainstream Plans. How will the Plan ensure effective services are provided to people with serious behavioral health conditions
9. Submit an attestation, signed and dated by the individual signing the responder's proposal, that the responder, its employees, subcontractors, and consultants have never been debarred, suspended, or excluded from any federal or State program.

C. Member Services

1. Describe how the required toll-free (required 8 am to 6 pm, 7 days a week) call line will be organized to provide screening and referral to BH services. Address the following:
   a. How it will be staffed during business hours?
   b. Distinguish between NYS area staff and those located outside of NYS.
   c. How will Plan ensure that staff understands the NYS system?
   d. The system backup plan to cover calls to the toll-free line.

      What are standards for call wait time, how is it supervised and standards maintained?

   Page limit: two (2).

2. Describe the qualifications of member services staff and supervisors who will be handling BH calls.

   Page limit: one (1).

   Plans wishing to be HARPS should respond to this question if the approach is different for HARP enrollees.

3. Describe the responder's plan to train member service staff on the requirements under this RFQ and ensure they understand the NYS system.

   Page limit: two (2).

4. Describe how behavioral health emergency calls will be managed by customer/member services, during regular business hours and during after-hours. Address the following:
   a. Indicate how it is determined that an emergency exists.
   b. Indicate how the caller is connected with an individual or service that can help.
   c. Indicate the proposed interface with mobile crisis teams and 911/fire/rescue.
   d. Indicate the licensure requirements for those responsible for call resolution and required follow up.

   Page limit: two (2).

   Plans wishing to be HARPS should respond to this question if the approach is different for HARP enrollees.

5. Describe how the responder will refer members requesting BH services to contracted providers. Address how:
   a. The responder will match members to contracted providers.
   b. The responder proposes to ensure choice of providers.
   c. The responder will track and manage requests for out-of-network and out-of-state providers.
   d. The responder will track and manage member's requests to change providers.
   e. The responder will assure contracted providers are accepting new referrals.
   f. The responder will confirm the individual was seen in a timely manner.

   Page limit: five (5).

   Plans wishing to be HARPS should respond to this question for both behavioral health and physical health.

6. Describe how the responder will ensure a comprehensive communication program to provide all eligible members, not just those members accessing services, with appropriate information about BH benefits and services, including how to access BH services, available providers, and member rights. Include a description of the standard materials to be included in the communications program at no additional cost to the State. Include the process for complying with annual notification of member rights given confidentiality concerns and the transient lifestyle of some BH consumers.

   Page limit: three (3).

Plans wishing to be HARPS should respond to this question for both behavioral health and physical health.

7. Provide an example of the responder's member communications that best reflect the system goals and operating principles outlined in the RFQ.

   Page limit: two (2) plus up to five (5) pages of sample communication materials.

D. Eligibility and Enrollment in the HARP

1. Describe the responder's plan for enrolling initial HARP populations, referring subsequent HARP eligible populations to an enrollment broker, and for managing HCBS services consistent with this RFQ. Include the following:
   a. How the responder will identify and conduct outreach with consumers that meet HARP targeting criteria but have not been evaluated yet for enhanced benefit eligibility to ensure understanding of the benefits and services available to them.
   b. An example of a successful outreach program and identify the customer(s) who can verify the experience described.
   c. Protocols to ensure that HCBS eligibility determinations are based on consistent application of established assessment criteria across assessors and not limited based on the availability of resources.
   d. The process the responder will use to inform the applicant of his or her right to appeal eligibility determinations.
   e. The process the responder will use to support the Plan's/HARPs enrollment process, including training and staff development and technology supports to automate the identification of potentially eligible HARP consumers and referral to enrollment brokers to enroll in a HARP.

   Page limit: five (5).

E. Network Management

1. Describe the inter-relationship between network development, provider relations, and QM.

   Page limit: two (2).

2. Describe the responder's approach to contracting with the current BH provider delivery system including OMH and OASAS licensed and certified providers, to assure:
   a. Continuity of care during the program implementation and start-up period.
   b. Compliance with network service standards listed in this RFQ.
   c. Timeliness of contracting and provider credentialing.

   Page limit: two (2).

3. Describe how the responder will conduct a needs assessment and develop a network Plan to identify and close network gaps prior to the "go-live" date for the RFQ. Address current and planned Medicaid BH benefits.

   Page limit: two (2)

   Page limit: two (2).

4. Describe how the responder has developed BH services specifically tailored to the needs of special populations and describe the populations (e.g., Transition Age Youth, individuals with co-occurring medical conditions). Provide an example of a state contract where the responder has had success in tailoring BH services to these populations and identify the customer reference(s) that can verify the experience described. Please relate this experience to your plan for BH in NYS.

   Please note in your response if alternative experience is being claimed as discussed in Section 3 and fill out the response accordingly.

   Page limit: two (2).

5. Describe at least one (1) goal, strategy, and measureable outcome, from a public sector client, where improvements in the availability of and member engagement in culturally appropriate BH services (as defined in Section 2.0 of the RFP) occurred. Identify the customer reference(s) that can verify this experience.

   Please note in your response if alternative experience is being claimed as discussed in Section 3 and fill out the response accordingly.

   Page limit: two (2).

6. Describe the responder's process to expedite temporary (or provisional) credentialing and privileging including OMH and OASAS licensed and certified providers, to expedite adding specialty providers to maintain network sufficiency, including how this data will be tracked, trended, and used to identify and close network gaps.

   Page limit: one (1).

7. Describe how, during the period of network development, the responder will assist providers to meet credentialing requirements.

   Page limit: one (1).

8. Provide an example of a typical provider training schedule for a public sector BH customers, BH providers, or similar providers and describe how provider training needs were determined.

   Page limit: two (2)

9. Describe strategies the responder has used to assist providers with limited Medicaid billing experience. Provide an overview of the training strategies you would use in NYS and describe how this would be coordinated with RPCs. Provide a reference for the responder's experience assisting providers with Medicaid billing.

   Page limit: one (1).

10. Describe the responder's process for evaluating and making a determination to retain providers. Describe the performance and quality improvement data and the strategies utilized to address performance improvement during the re-credentialing process.

    Page limit: two (2).

11. Provide an example of how the responder has assisted another government/public sector managed BH client to successfully move from fee-for-service to managed care/capitation or to implement payment reform with network providers. Include the challenges and strategies

to overcome those challenges. Identify the customer reference(s) that can verify the experience described.

Page limit: two (2).

12. Describe the responder's provider profiling system and how it will be modified for the new BH services and BH provider network added by this RFQ.
    a. List typical profiling elements.
    b. Provide one sample ambulatory provider profiling report and one sample inpatient provider profiling report.
    c. Indicate how profiling elements differ by provider type or level of care.
    d. Describe the process for collecting accurate baseline data that engenders provider confidence and the time table for development of accurate baseline data.
    e. Include a description of the parties who will have access to the provider profile and how the information will be utilized.

    Page limit: four (4).
13. Describe the responder's experience with evaluating provider performance based on an array of quality metrics. Discuss any experience establishing provider quality tiers that are tied to differential reimbursement or preferred status for non-financial incentives (such as higher volume of referrals or less hands on utilization review). Describe experience using incentives to reward high performing providers. Identify the customer reference(s) that can verify the experience described.

    Page limit: two (2).
14. Describe the responder's approach to implementing a comprehensive crisis screening, diversion, stabilization, and referral system with statewide access to telephonic, mobile, and site-based services for Medicaid members. Address mental health and SUD crisis intervention. Keep in mind that where they exist, the State will require the Plan to contract with the existing crisis providers that serve both Medicaid and non-Medicaid populations and monitor the performance of crisis providers on access, quality, and cost effectiveness for Medicaid members.

    Page limit: three (3).
15. Provide an example of the responder's success in developing, implementing, and managing crisis diversion and response network providers, including any use of peers or recovery focused crisis strategies, such as WRAP and advanced directives. Identify a customer reference that can verify the experience described. Alternatively, describe the responder's plans to use peers or recovery focused crisis strategies, such as WRAP and advanced directives in development, implementing and managing crisis diversion and response services. Discuss the type of support for peer organizations the responder will provide (financial or non-financial) to develop peer and recovery focused strategies.

    Page limit: two (2).
16. Discuss strategies the responder has used to develop BH service alternatives to unnecessary inpatient utilization for adults, and Transition Age Youth, including those with

SUDs. Discuss the information utilized by the responder to inform the need for development of BH service alternatives. Provide an example from another client/state of an alternative service that was developed and effective in preventing unnecessary inpatient utilization. Alternatively, describe plans to develop BH service alternatives to unnecessary inpatient utilization for adults and Transition Age Youth, including those with SUDs. Discuss the information that will be utilized by the responder to inform the need for development of BH service alternatives. Discuss evidence-based or best practice approaches the responder may adopt to prevent unnecessary inpatient utilization.

Page limit: two (2).

HARP Only Network Questions

17. Describe how the responder will secure sufficient numbers of providers for BH services that will be new Medicaid BH services under the Demonstration Amendment in order to assure service access on the start-up date. What barriers are anticipated with having sufficient access by start-up date? What strategies would the responder employ to address these barriers?

    Page limit: two (2).

18. Describe your plan to assist NYS' Health Homes in staff development, to include recruitment, training and overseeing qualified staff to conduct functional assessments, annual re-determinations, and oversee Plans of care to ensure that 1915(i)-like benefits are administered with consistency and in compliance with federal HCBS requirements across all health homes. For Health Homes that contract with multiple Plans, provide a proposal for collaborating across Plans to avoid duplicate or conflicting requirements and efficient administration of requirements under the RFQ.

    Page limit: three (3).

19. Provide an example of how the responder has developed or transformed another public sector MH and SUD provider network to successfully achieve system goals and operating principles similar to those outlined in the RFQ. Include the challenges and strategies to overcome those challenges. Please relate this experience to your plan for BH in NYS. Identify the customer reference(s) that can verify the experience described.

    Please note in your response if alternative experience is being claimed as discussed in Section 3 and fill out the response accordingly.

F. Utilization Management

1. Describe how the responder will organize and implement the utilization/care management program for BH services. Address the following:
    a. Describe the workflow for the authorization of care. Address how the process will differ for acute and ambulatory levels of care and/or for special populations.
    b. Describe the workflow and processes for the denial of care.
    c. Describe how the responder will use data and clinical decision support to streamline and support utilization/care management. Include the following:
        i. Specify the types of data to be used.

ii. Specify which levels or care populations will be targeted.

iii. List the edits that will identify cases for review and/or clinical intervention, by level of care or category of service.

iv. Describe the care management interventions that will be utilized with any case or provider outliers.

v. Estimate the percent of cases that will be touched by edit, by intervention and in aggregate.

d. Describe the methodology for identifying over- and under-utilization of services. Provide sample reports and how the information in those reports would be used.

e. Provide an example from another contract for which the responder has detected under-utilization of services (across providers), what was done to impact the utilization, and how the effectiveness of the strategy was measured. Identify the customer reference(s) that can verify the experience described.

f. Provide an example from another contract for which the responder has detected over-utilization of services (across providers), what was done to impact the utilization and how the effectiveness of the strategy was measured. Identify the customer reference(s) that can verify the experience described.

Page limit: ten (10) exclusive of report samples.

2. Describe the level of care guidelines utilized by the responder's organization in making level of care/medical necessity determinations for mental health services and programs.

   a. List the source of the level of care guideline with which the responder has experience.

   b. List the BH services that are currently covered by the guidelines.

   c. Describe how a provider has or will adapt current practice to state specific standards and to address all MH levels of care requiring prior authorization and concurrent review under the RFQ in Section 3.9.

   d. Describe how you will update the guidelines to include NYS specific services that are not currently addressed by the guideline, including enhanced services under the HARP.

   e. Describe how you will incorporate the use of LOCADTR to make level of care/medical necessity determinations for SUD services, including how you will train UM and MM staff.

   Page limit: one (1).

3. Describe the BH clinical practice guidelines utilized by the responder's organization in managing care. Address the following:

   a. List the BH clinical practice guidelines required under the RFP in Section 3.10 with which the responder has experience. Include the source of each guideline.

   b. Describe any clinical practice guidelines that the responder proposes to use in addition to those required in the Section 3.10.

   c. Describe your organization's experience and/or planned approach for disseminating and monitoring fidelity to clinical practices guidelines in the network.

   Page limit: five (5).

4. Describe your organization's proposed approach to training utilization/care managers and clinical peer reviewers, including after-hours clinicians to address the following:
   a. The application of the level of care guidelines, including how UM and inter-rater reliability protocols will be adapted to address all covered services under the RFQ.
   b. The incorporation of recovery principles into the care management process.
   c. The incorporate of EBPs in the utilization review/care management process.

   How will training be modified to reflect the BH services covered by this RFQ?

   Page limit: one (1).
5. Describe the ongoing monitoring protocols for utilization/care managers and physician advisors. Include the nature and frequency of supervision, documentation audits, call monitoring, inter-rater reliability training, and other oversight activities for assuring the level of care guidelines are properly and consistently applied in the utilization review, care management, and Medical Management process.

   Page limit: two (2).
6. List the clinical quality triggers (i.e., frequent readmissions) for which consultation by a physician or psychologist Clinical Peer Reviewer *for reasons other than medical necessity* will be required and describe how you will ensure that such consultation consistently occurs.

   Page limit: two (2).
7. Describe your plan for conducting post-discharge ambulatory follow up. Address staff qualifications and training, the timing of the outreach, and the nature of the follow-up interventions.

   Page limit: one (1).

HARP Only Utilization Management Questions

8. Describe the process for prior authorization of 1915(i)-like services, including how required clinical information shall be submitted and reviewed and the process for denial of any portion of a recommended plan of care. Include the resources and infrastructure that the respondent will use to monitor HARP enrollees and how core benefits and 1915(i)-like benefits will be integrated into the Plan of care for HARP members.

Page limit: two (2).

G. Clinical Management

1. Describe the responder's experience with and/or planned approach to implementing BH-medical integration initiatives. Include the following:
   a. The target populations, including BH and medical conditions.
   b. Your identification strategies using screening tools and data mining.
   c. Training and engaging Health Homes and primary care and BH providers in screening and appropriate care coordination.
   d. Your consumer engagement and intervention strategies, including how you will use Health Homes and Peers in the engagement process.

e. Data exchange protocols, if you plan to use a partner/delegated entity.

f. Data sharing (e.g., pharmacy, medical, and BH claims) and communication protocols with providers and care managers to improve care coordination and health outcomes.

Page limit: three (3).

2. Describe the responder's experience with implementing substance use medication assisted therapies, including site-based and mobile delivery models.

   Page limit: one (1).

3. Describe the Responder's strategy to ensure the required BH-medical integration requirements indicated in Section 3.10 (Clinical Management) are met within six months after implementation.

   Page limit: one (1).

4. Plans typically do not have experience managing services specific to SUD including methadone treatment and residential services. The members who access these services may have significant functional deficits and may require long-term clinical treatment and rehabilitative services to return to or maintain functioning. Please describe any experience you have managing these services, or describe your approach to managing these benefits.

   Page limit: four (4)

HARP Only Clinical Management Questions

5. Describe the responders approach to implementing a single plan of care for HARP enrollees that integrates physical health, BH core benefits, BH enhanced benefits and non-Medicaid funded services. Describe the role of the Health Home in your response.

   Page limit: one (1).

6. Describe strategies the HARP would use to assist members to obtain and maintain housing other than at the recipient level. Discuss the responder's experience in at least two (2) actual examples of managing access to housing and supportive services including actions, strategies taken, and results. If the responder has experience with Supportive Housing, provide a description for at least one of the requested examples, including details of how members accessed housing and services and the Plan's role in collaborating with housing organizations. Identify the customer(s) that can verify this experience.

   Page limit: three (3).

7. Describe how the responder will meet clinical management requirements for HARP members including but not limited to individuals with SMI, individuals with FEP, individuals residing in Supportive Housing or other types of community housing, homeless adults, individuals with criminal justice involvement, methadone patients, and/or Transition Age Youth. Describe the responder's experience with at least two (2) actual examples including the actions and strategies taken and results. Identify the customer(s) that can verify this experience.

   Page limit: four (4).

8. Describe the responder's strategy to develop and implement the protocol for screening for unmet medical needs in HARP enrollees as required in Section 3.10 M.iii.

   Page limit: one (1).

H. Cross System Coordination

1. Describe the strategies the responder will use to facilitate cross agency systems collaboration with the Plan. Separately address the following:
   a. Collaboration with OMH, OASAS, and SDOH and LGUs to coordinate Medicaid and State funded or administered non-Medicaid services.
   b. Collaboration with RPCs.
   c. Collaboration with OMH, OASAS, and SDOH and LGUs to ensure continuity of care for Transition Age Youth.
   d. Collaboration between contracted BH providers and PCPs.
   e. Collaboration with other member serving agencies (e.g., criminal justice, social service system).
   f. Describe the responder's experience in at least two (2) actual examples of collaboration including the actions and strategies taken and results. Identify the customer(s) that can verify this experience.

   Page limit: three (3).
2. Describe the responder's experience with implementing coordination strategies to assist Transition Age Youth transitioning from the children's specialty managed care system. Discuss strategies to collaborate with social services and educational systems as well as other involved payors and agencies. Identify the customer reference(s) that can verify the experience described.

   Page limit: one (1).

I. Quality Management

1. Describe how the QM Plan will be revised to address BH requirements under the Contract. Address the following:
   a. Committee structure, responsibility, and membership.
   b. Necessary data sources.
   c. Monitoring activities (e.g., performance measures, PIPs, surveys, studies, profiling, audits, etc.).
   d. Feedback loops.

   Page limit: five (5).
2. Describe how the responder will involve BH consumers, family members, responder personnel, BH network providers, and other stakeholders in the development and ongoing work of the QM system specific to the requirements under this RFQ.

   Page limit: one (1).

3. Describe how the UM Plan will be revised to address BH requirements under the RFQ. Address the following:
   a. Committee structure, responsibility, and membership.
   b. Quality metrics.
   c. Necessary data sources.
   d. Monitoring activities.

   Page limit: five (5).
4. Describe how the responder will identify quality of care concerns during care management for BH recipients and how this information will be used to improve the quality of care provided to BH recipients at both the consumer and system level.

   Page limit: two (2).

HARP Only QM Questions

5. Describe how the responder will comply with federal requirements for HCBS under the 1915(1)-like component of the Demonstration Amendment, including evaluating the adequacy of Plans of care and that services are implemented consistent with the Plans of care.
6. Describe the responder's experience with implementing HCBS quality assurance performance measures and the information system infrastructure that the HARP has to support the required HCBS quality assurance reporting.

J. Reporting and Data Exchange

1. Describe how the responder's information systems and reporting functions will be reorganized and updated to address BH reporting requirements. Address the following:
   a. Describe how the responder's information management system will maintain information on provider types, population, and clinical specialties to support directing members to the most appropriate services and providers.
   b. Describe an experience with receiving and loading provider information to accommodate a state's BH provider network. If similar experience is claimed, please note this and answer accordingly.
   c. Provide example BH reports that demonstrate the responder's current capabilities to meet BH reporting requirements. Where gaps exist between current capabilities and required reporting elements, describe your Plan, with a timeline for how the gaps will be closed.

   Page limit: three (3) excluding sample reports.
2. Provide two (2) examples for which responder has implemented a performance improvement initiative that demonstrated documented improvement in the quality of BH services or supports. Include the nature of the problem, the nature of the intervention(s), how information from multiple data sources was utilized, what feedback loops were in place, and the outcome. Identify the customer reference(s) that can verify the examples. If similar experience is claimed, please note this and answer accordingly.

Page limit: four (4).

3. Propose a Plan for implementing BH content on the responder's website to be utilized by members and family members, providers, stakeholders, and State agencies that provides a provider directory, education and advocacy information as described in the RFQ. Discuss the proposed content of the website in respect to promoting holistic health and wellness. Provide access to an active website that has been developed for a State agency, including information to permit access to the site (uniform resource locator, log-in identification, and password). Describe the development tools that will be utilized to create the website as well as the proposed security protocols that will be used.

   Page limit: eight (8).

4. If a delegated entity will be used, describe the responder's experience with two way data exchange to support BH-medical integration initiatives. Include the following and identify the customer reference(s) that can verify the experience.
   a. The type of data exchanged (e.g., medical claims, pharmacy claims, Human Resources Administration data).
   b. The volume and frequency of data exchanged.
   c. How the data is used to support integration initiatives.

   Page limit: four (4).

HARP Only Reporting Questions

5. Describe the HARPs plan for capturing and reporting HCBS services and your organizations' plan to automate submission of functional assessment and plan of care data to support monitoring of compliance with HCBS requirements and reporting of HCBS assurances/sub-assurances and recovery outcomes.

K. Claims Administration

1. Describe the responder's experience for processing Medicaid claims specific to those services being added under the RFQ, including prior and current clients, type of claims administration (ASO or at risk), and the number of covered lives.
2. Describe the responder's capability to conduct the following functions, specific to those services being added under the RFQ:
   a. Receive and send HIPAA transaction formats in regards to claims, eligibility and authorizations. Include processes for non-electronic claim submissions.
   b. Describe the responder's capability to meet timeliness and accuracy of payments requirements.
   c. Describe the responder's ability to successfully submit encounter data.
   d. Provide a list the responder's claims system edits.

   Page limit: two (2).

3. Describe the responder's experience with implementing a comprehensive fraud and abuse monitoring program for a managed BH Contract with a government/public sector customer. Include three (3) examples of fraud or abuse responder has detected for government/public

sector managed BH program and what responder did upon detection. Identify customer(s) who can verify the experience.

Page limit: three (3).

L. Financial Management

1. Describe the responder's experience in producing standard and ad-hoc reports for submission to the State as required in Sections 3.16 and Attachment A of this RFQ. Provide three (3) sample reports similar to those required in Sections 3.16 and Attachment A of this RFQ.

   Page Limit: two (2) not including sample reports.

2. Describe in detail your methodology surrounding the calculation of incurred but not reported liability. Specifically address the data sources, frequency of review and the qualifications of the internal or external review parties."
3. Describe the responder's experience and planned methodology for producing required financial reports segregated by all rating categories for which a capitation rate is paid and for all applicable funding sources.
4. Applicants must complete financial statements which consist of the following:
   a. Projected membership.
   b. A revenue and expenses statement by month for the first 36 months of operation of the new program (HARP) or break even, whichever is longer.
   c. A consolidated summary revenue and expense statement by year for each line of business operated by the MCO for the first three years of the program, or until the MCO reaches breakeven, whichever is later.
   d. A pro-forma balance sheet as of the date of the initial enrollment in the counties where the new program is and for each of the first three years of the new program or until the MCO reaches breakeven, whichever is later.
5. Applicants must also include the source of any additional capitalization that may be needed to support the new program and to meet reserve requirements during the first three years. If the source is a subordinated loan (patterned after Section 1307 of State Insurance Law) or surplus note, the proposed loan document must be submitted. At a minimum, the plan's capital should be sufficient to comply with NYS escrow and contingent reserve requirements on an ongoing basis (Health Department's Regulation Part 98-1.11), fund the cumulative operating loss sustained through the time break-even point is reached, and provide additional resources to cover unanticipated losses.

Attachment A — Draft BH Reporting Requirements

In addition to the reporting requirements in the managed care model contract, Plans must meet the following reporting requirements:

#	Report	Frequency[12]
Plan		
1	Implementation Plan Status Updates	Weekly for duration of implementation
2	Network Analysis and Inventory[13]	Annually
3	Network Development Plan	Annually
4	Network Development Plan Status Update[14]	Quarterly*
5	Inpatient Provider Profiling [15]	Annually beginning year 2
6	Cost and Utilization[16]	Quarterly/Annually
7	Performance Improvement Plan Updates	Quarterly*
8	Performance Measures	As specified in BH and HARP addendums to QARR
9	Appointment Availability Survey	Annually
10	Consumer satisfaction survey	Annually
HARP Additional Requirements		
11	UM Plan and Work Plan	Annually
12	UM Evaluation Report	Annually
13	QM Plan and Work Plan	Annually

[12] For items with an asterisk, monthly reporting may be required at contract start or at any time determined necessary by the State. In the event of monthly reporting, the due date will be 30 days after the month end.

[13] To include number of providers by provider type, by zip code, and geographic analysis of member access to two or more providers by provider type (e.g., inpatient psych, inpatient drug and abuse, residential, MD, non-MD).

[14] To include analysis of need using multiple data sources to include, but not be limited to consumer satisfaction, access to care delays, out of network authorizations, single case agreements, etc., network development plan for addressing need and progress on key development initiatives; also to include number of providers credentialed, percent of providers credentialed within 60 days, number of provider in credentialing, and average length of time in process, number of providers voluntarily terminated by reason code, number of providers involuntarily terminated by reason code, number of providers recredentialed and recredentialing status of remaining providers; reported separately by provider type (e.g., organizational, practitioner).

[15] At a minimum, shall be available for all facility providers and shall include utilization and quality metrics such as readmissions, average length of stay, post-discharge connectedness to ambulatory services.

[16] At a minimum, Plans will track and report on medical loss.

#	Report	Frequency[12]
14	QM Evaluation Report	Annually
15	Consumer satisfaction survey	Annually
16	HCBS Compliance Report	As specified in Attachment E

Attachment B — CMS Standard HARP Reporting and Monitoring Requirements

These home and community-based assurances and sub-assurances are CMS requirements for managed long term services and supports. The metrics and formulas are typical for programs such as this program and are required by CMS and its quality management contractor for demonstrating compliance with these assurances and sub-assurances. The State will negotiate the metrics and calculation of those metrics with CMS and work with the Plans to streamline all requirements associated with these quality assurance requirements.

#	CMS Assurance	CMS Sub-Assurance	Metric – based on CMS requirements approved in other states	Formula – based on CMS requirements approved in other states
1	Level of care (LOC): The processes and instruments described in the approved 1915(i)—like authority are applied appropriately and according to the approved description to determine if the needs-based criteria are met.	An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.	The percent of adults that met level of need (LON) requirements prior to receiving 1915(i)-like services.	Data source: LON approvals. Data collection responsible party: MCO. Frequency of data collection: Continuously and ongoing. Sampling: 100% review. Data aggregation responsible party: MCO and the DOH. Frequency of data aggregation and analysis: Monthly.
		The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant LOC.	The percent of initial LON forms/instruments completed as required in approved demonstration. The percent of LON determinations made by a qualified evaluator. The percent of annual	Data source: Record reviews, on-site OR Utilization Review Unit completed LON Data collection responsible party: MCO Frequency of data collection: Continuously and ongoing Sampling: Representative sample, 95% Confidence Interval (CI).

#	CMS Assurance	CMS Sub-Assurance	Metric – based on CMS requirements approved in other states	Formula – based on CMS requirements approved in other states
			determinations where level of need criteria were correctly applied.	Data aggregation responsible party: MCO and DOH Frequency of data aggregation and analysis: Monthly
2	Participant safeguards/health and welfare: The State identifies addresses and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.	The State demonstrates on an ongoing basis that it identifies addresses and seeks to prevent incidents of abuse, neglect, exploitation, and unexplained death.	Percent of grievances filed by participants that were resolved within 14 calendar days according to approved waiver guidelines.	Data source: Record reviews, onsite Data collection responsible party: MCO. Frequency of data collection: Monthly. Sampling: 100% review. Data aggregation responsible party: DOH. Frequency of data aggregation and analysis: Monthly.
			Percent of participants who received information on how to report the suspected abuse, neglect, or exploitation of adults.	Data source: Record reviews, onsite. Data collection responsible party: MCO. Frequency of data collection: Continuously and ongoing. Sampling: Representative sample, 95% CI Data aggregation responsible party: MCO and DOH. Frequency of data aggregation and analysis: Continuously and ongoing.

#	CMS Assurance	CMS Sub-Assurance	Metric – based on CMS requirements approved in other states	Formula – based on CMS requirements approved in other states
			Percent of reports related to abuse, neglect and exploitation of participants where an investigation was initiated within the established timeframe. Number and percent of substantiated cases of abuse, neglect and exploitation where recommended actions to protect health and welfare were implemented.	Data source: MCO abuse, neglect, or exploitation database. Data collection responsible party: MCO. Frequency of data collection: Monthly. Sampling: 100% review. Data aggregation responsible party: DOH. Frequency of data aggregation and analysis: Monthly.
		The State demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.	Number and percent of participants' critical incidents that were reported, initiated, reviewed and completed within required timeframes as specified in the approved waiver.	Data source: MCO critical incidents database Data collection responsible party: MCO. Frequency of data collection: Monthly. Sampling: 100% review. Data aggregation responsible party: MCO. Frequency of data aggregation and analysis: Monthly.
		The State policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion)	Number and percent of unauthorized uses of restrictive interventions that were appropriately reported.	Data source: MCO restrictive interventions database or records review, on-site Data collection responsible party: MCO.

#	CMS Assurance	CMS Sub-Assurance	Metric – based on CMS requirements approved in other states	Formula – based on CMS requirements approved in other states
		are followed.		Frequency of data collection: Monthly. Sampling: 100% review. Data aggregation responsible party: MCO. Frequency of data aggregation and analysis: Monthly.
		The State establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.	Number and percent of HCBS participants who received physical exams consistent with state 1915(i)-like policy.	Data source: MCO encounter data database Data collection responsible party: MCO. Frequency of data collection: Monthly. Sampling: 100% review. Data aggregation responsible party: MCO. Frequency of data aggregation and analysis: Monthly.
3	The State demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.	Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.	Percent of participants reviewed with a POC that was adequate and appropriate to their needs and goals (including health goals) as indicated in assessment(s) Percent of participants reviewed with a POC that had adequate and appropriate strategies to address their	Data source: Record reviews, onsite or through Utilization Review Unit. Data collection responsible party: MCO. Frequency of data collection: Continuously and ongoing. Sampling: Representative sample, 95% CI Data aggregation responsible party: MCO and DOH. Frequency of data aggregation

#	CMS Assurance	CMS Sub-Assurance	Metric – based on CMS requirements approved in other states	Formula – based on CMS requirements approved in other states
			health and safety risks as indicated in the assessment(s). Percent of participants reviewed with a POC that addressed the participant's goals/needs as indicated in the assessment(s).	and analysis: Monthly.
		Service plans are updated/revised at least annually or when warranted by changes in participant's needs.	Percent of participants whose POC was updated within 365 days of the last evaluation. Percent of participants whose POC was updated as warranted by changes in the participant's needs.	Data source: MCO database. Data collection responsible party: MCO. Frequency of data collection: Ongoing. Sampling: 100% review. Data aggregation responsible party: MCO. Frequency of data aggregation and analysis: Quarterly.
		Services are delivered in accordance with the service Plan, including the type, scope, amount, duration, and frequency specified in the service plan.	Percent of new participants receiving services according to their POC within 45 days of approval of their POC. Percent of participants who received services in the type, amount, duration, and frequency specified in the POC.	Data source: Person-centered Plan record reviews financial records. Data collection responsible party: MCO. Frequency of data collection: Quarterly. Sampling: Representative sample, 95% CI. Data aggregation responsible party: MCO. Frequency of data aggregation

#	CMS Assurance	CMS Sub-Assurance	Metric – based on CMS requirements approved in other states	Formula – based on CMS requirements approved in other states
				and analysis: Semi-annually.
		Participants are afforded choice between/among waiver services and providers.	Percent of participant records reviewed with a completed, signed freedom of choice form that specifies choice was offered among waiver services and providers. Percent of participants reviewed with a POC that includes the participant's and/or guardian/caregiver's signature as consistent with state and federal guidelines.	Data source: Record reviews, onsite. Data collection responsible party: MCO. Frequency of data collection: Continuously and ongoing. Sampling: Representative sample, 95% CI. Data aggregation responsible party: MCO and DOH. Frequency of data aggregation and analysis: Semi-annually.
4	Qualified providers: Providers meet required qualifications.	The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.	Percent of waiver providers providing waiver services who meet licensure and certification requirements prior to furnishing waiver services — initially. Percent of waiver providers providing waiver services who meet licensure and certification requirements prior to furnishing waiver services — continuously. Percent of waiver providers providing waiver services who have an active agreement	Data source: MCO credentialing files. Data collection responsible party: MCO. Frequency of data collection: Continuously and ongoing. Sampling: 100% review. Data aggregation responsible party: MCO. Frequency of data aggregation and analysis: Quarterly. Note: The State and CMS may want the data stratified by licensed, certified and atypical to ensure that they can pinpoint deficiencies in MCO

#	CMS Assurance	CMS Sub-Assurance	Metric – based on CMS requirements approved in other states	Formula – based on CMS requirements approved in other states
			with the MCO.	credentialing.
		The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.	Percent of providers of waiver services who meet training requirements — non-licensed/noncertified provider, training requirements.	Data source: Training verification records. Data collection responsible party: MCO. Frequency of data collection: Monthly. Sampling: 100% review. Data aggregation responsible party: DOH. Frequency of data aggregation and analysis: Quarterly. Note: New York may be able to combine PMs in this sub-assurance and the next sub-assurance. However, the State and CMS may want the data stratified by licensed, certified and atypical to ensure that they can pinpoint deficiencies in MCO training.
		The State implements its P&Ps for verifying that provider training is conducted in accordance with State requirements and the approved waiver.	Percent of providers of waiver services who meet training requirements — all providers, ongoing training requirements.	Data source: Training verification records. Data collection responsible party: MCO. Frequency of data collection: Monthly. Sampling: 100% review. Data aggregation responsible party: DOH. Frequency of data aggregation and analysis: Quarterly

#	CMS Assurance	CMS Sub-Assurance	Metric – based on CMS requirements approved in other states	Formula – based on CMS requirements approved in other states
			Number of provider trainings operated by the MCO.	Data source: Training verification records. Data collection responsible party: MCO. Frequency of data collection: Quarterly. Sampling: 100% review. Data aggregation responsible party: DOH. Frequency of data aggregation and analysis: Quarterly.
5	Administration and operation: The State Medicaid Agency (SMA) retains ultimate authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by contracted entities.		Number and/or percent of aggregated performance measure reports generated by the MCO and reviewed by the DOH that contain discovery, remediation, and system improvement for ongoing compliance of the assurances. Number and/or percent of MCO administrative and quality assurance reports approved by DOH prior to implementation by the MCO.	Data source: Reports to DOH on delegated administrative functions. Data collection responsible party: MCO. Frequency of data collection: Monthly. Sampling: 100% review. Data aggregation responsible party: MCO. Frequency of data aggregation and analysis: Monthly.
6	Financial accountability: The DOH maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i)-like participants by qualified providers. The State must demonstrate	The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.	Percent of providers who have payment recouped for waiver services without supporting documentation.	Data source: Routine Medicaid claims verification audits. Data collection responsible party: MCO. Frequency of data collection: Continuously and ongoing. Sampling: 90% CI. Data aggregation responsible party: MCO. Frequency of data aggregation

#	CMS Assurance	CMS Sub-Assurance	Metric – based on CMS requirements approved in other states	Formula – based on CMS requirements approved in other states
	that it has designed and implemented an adequate system for insuring financial accountability of the waiver program.			and analysis: Continuously and ongoing.
			Percent of claims verified through the MCO's compliance audit to have paid in accordance with the participant's waiver treatment Plan.	Data source: MCO's compliance report. Data collection responsible party: MCO. Frequency of data collection: Quarterly or Continuously and On-going. Sampling: 95% CI. Data aggregation responsible party: MCO and DOH. Frequency of data aggregation and analysis: Quarterly.
		The State provides evidence that rates remain consistent with the approved rate methodology throughout the five-year waiver cycle.	The State pays the MCO actuarially sound rates.	N/A to MCO reporting.

Attachment C: HCBS Service Definitions for HARPs

Rehabilitation

Psychosocial Rehabilitation (PSR) and Community Psychiatric Support and Treatment (CPST) services are provided as part of a comprehensive specialized psychiatric program available to all Medicaid eligible adults with significant functional impairments meeting the need levels in the 1915(i)-like authority resulting from an identified mental health or substance use disorder diagnosis. The medical necessity for these rehabilitative services must be determined by a licensed behavioral health practitioner or physician who is acting within the scope of his/her professional license and applicable state law and furnished by or under the direction of a licensed or credentialed practitioner, to promote the maximum reduction of symptoms and/or restoration of an individual to his/her best age-appropriate functional level conducting an assessment consistent with state law, regulation, and policy. Rehabilitation services can be provided to motivate an individual to select goals that he or she would like to accomplish but are unable to due to their behavioral health condition. Individuals may be engaged to identify personal life role goals for employment, education and/or housing and supported to engage in comprehensive services in order to attain such goals. Services will be reviewed during the planning process to insure that no duplication exists. A unit of service is defined according to the Healthcare Common Procedure Coding System (HCPCS) approved code set unless otherwise specified

Psychosocial Rehabilitation:

Definitions:

PSR services are designed to assist the individual with compensating for or eliminating functional deficits and interpersonal and/or environmental barriers associated with their behavioral health condition. Activities included must be intended to achieve the identified goals or objectives as set forth in the individual's Individual Treatment Plan. The intent of PSR is to restore the individual's functional level to the fullest possible and as necessary for integration of the individual as an active and productive member of his or her family, community, and/or culture with the least amount of ongoing professional intervention. PSR is a face-to-face intervention with the individual who has a behavioral health diagnosis present. Services may be provided individually or in a group setting and should utilize (with documentation) evidence-based rehabilitation interventions. This service may include the following components:

- Rehabilitation counseling, and support to restore social and interpersonal skills necessary to increase community tenure, enhance interpersonal skills, establish support networks, increase community awareness, develop coping strategies, and effective functioning in the individual's social environment including home, work, and school.
- Rehabilitation, counseling and support to develop skills necessary to improve self-management of the negative effects of psychiatric, emotional symptoms, or recurrent relapse to substance use that interfere with a person's daily living, and daily living skills that are critical to remaining in home, school, work, and community. Rehabilitation counseling and support necessary for the individual to implement learned skills so the person can remain in a natural community location.

- Rehabilitation counseling and support necessary for the individual to implement learned skills so the person can remain in a natural community location.
- Rehabilitation counseling and support necessary for the individual to participate in volunteer activities for pre-vocational or civic duty purposes.
- Assisting the individual with effectively responding to or avoiding identified precursors or triggers that result in functional impairments.
- Ongoing in-vivo assessment of the individual's functional skill and impairment levels that is used to select PSR interventions and periodically assess their effectiveness in achieving goals. Workers who provide PSR services should periodically report to a supervising licensed practitioner on participants' progress toward the recovery and re-acquisition of skills.

These services may complement, not duplicate, services aimed at supporting an individual to achieve an employment-related goal in their plan of care. The total combined hours for Psychosocial Rehabilitation and Community Psychiatric Support and Treatment are limited to no more than a total of 500 hours in a calendar year.

Community Psychiatric Support and Treatment (CPST):

The CPST services are defined as follows:

CPST are goal-directed supports and solution-focused interventions intended to achieve identified goals or objectives as set forth in the individual's Individual Treatment Plan. CPST is a face-to-face intervention with the individual, family or other collateral supports. The service may include the following components to meet the needs of the individuals with mental health or mental health co-occurring diagnosis:

- Assist the individual and family members or other collateral supports to identify strategies or treatment options associated with the individual's mental illness, with the goal of minimizing the negative effects of mental illness symptoms or emotional disturbances or associated environmental stressors which interfere with the individual's daily living, financial management, housing, academic and/or employment progress, personal recovery or resilience, family and/or interpersonal relationships, and community integration.
- Provide individual supportive counseling, solution-focused interventions, emotional and behavioral management, and problem behavior analysis with the individual, with the goal of assisting the individual with social, interpersonal, self-care, daily living, and independent living skills to restore stability, to support functional gains and to adapt to community living.
- Facilitate participation in and utilization of strengths based planning and treatments which include assisting the individual and family members or other collateral supports with identifying strengths and needs, resources, natural supports, and developing goals and objectives to utilize personal strengths, resources, and natural supports to address functional deficits associated with their mental illness.

- Assist the individual with effectively responding to or avoiding identified precursors or triggers that would risk their remaining in a natural community location, including assisting the individual and family members or other collateral supports with identifying a potential psychiatric or personal crisis, developing a crisis management plan and/or as appropriate, seeking other supports to restore stability and functioning.
- Provide restoration, rehabilitation, assistance with employment, housing and education goals, and support to connect with additional services for attaining and sustaining the identified goals.
- Assist the individual with daily living skills specific to managing their own home including managing their money, medications, and using community resources and other self-care requirements.
- Implement interventions using evidence-based techniques, drawn from cognitive-behavioral therapy and other evidence-based psychotherapeutic interventions that ameliorate targeted symptoms and/or recover the person's capacity to cope with or prevent symptom manifestation.

  The total combined hours for Psychosocial Rehabilitation and Community Psychiatric Support and Treatment are limited to no more than a total of 500 hours in a calendar year.

Crisis Intervention

Mobile Crisis Intervention:

Mobile Crisis Intervention (CI) services are provided as part of a comprehensive specialized psychiatric services program available to all Medicaid eligible adults with significant functional impairments meeting the need levels in the 1915(i)-like authority resulting from an identified mental health or co-occurring diagnosis.

Definitions:

- CI services are provided to a person who is experiencing a psychiatric crisis, are designed to interrupt and/or ameliorate a crisis experience including a preliminary assessment, immediate crisis resolution and de-escalation. The goals of CIs are engagement, symptom reduction, stabilization, and restoring individuals to previous level of functioning. All activities must occur within the context of a potential or actual psychiatric crisis. CI is a face-to-face intervention and can occur in a variety of locations, including an emergency room or clinic setting, or other community locations where the person lives, works, attends school, and/or socializes. CI services include the following components:
  - Referral and linkage to appropriate community services to avoid more restrictive levels of treatment.
  - A preliminary assessment of risk, mental status, and medical stability; and the need for further evaluation or other mental health services. Includes contact with the client, family members, or other collateral sources (e.g. caregiver, school personnel) with pertinent information for the purpose of a preliminary

assessment, treatment and/or referral to other alternative mental health services at an appropriate level.

- Short-term CIs include crisis resolution and de-briefing with the identified Medicaid eligible individual and the treatment provider.
- Follow-up with the individual, and when appropriate, with the individuals' caretaker and/or family members.
- Consultation with a physician or other qualified providers to assist with the individual's specific crisis.

Empowerment Services - Peer Supports

Peer Support (PS) services are peer-delivered services with a rehabilitation and recovery focus designed to promote skills for coping with and managing behavioral health symptoms while facilitating the utilization of natural resources and the enhancement of recovery-oriented principles such as hope and self-efficacy, and community living skills. Activities included must be intended to achieve the identified goals or objectives as set forth in the consumer's individualized care plan, which delineates specific goals that are flexibly tailored to the consumer and attempt to utilize community and natural supports.

Peer supports services are also intended for outreach and engagement activities and to help people with supports as they move from one level of care to another.

The structured, scheduled activities provided by this service emphasize the opportunity for peers to support each other in the restoration and expansion of the skills and strategies necessary to move forward in recovery. Persons providing these services will do so through the paradigm of the shared personal experience of recovery.

Certified Peer Specialists are appropriately supervised treatment team members who will play an integral role in care planning including the Wellness Recovery Action Plan (WRAP), treatment planning and the development of psychiatric advance directives (PAD). Training for Peer Specialists will be provided/contracted by OMH and OASAS and will focus on the principles and concepts of recovery, coping skills, and advocacy, the unique competencies needed to assist another individual based on the shared personal experience paradigm.

Peer support services are limited to no more than a total of 500 hours in a calendar year. Individuals receiving SUD outpatient treatment may not also receive this duplicative service.

Habilitation

Habilitation Services

Habilitation services are typically provided on a 1:1 basis and are designed to assist participants with a mental health or mental health co-occurring diagnosis in acquiring, retaining and improving skills such as communication, self-help, domestic, self-care, socialization, fine and gross motor skills, mobility, personal adjustment, relationship development, use of community resources and adaptive skills necessary to reside successfully in home and community-based settings. Habilitation services are necessary, as specified by the service plan, to enable the participant to integrate more fully into the community and ensure the health, welfare and safety of the participant.

Habilitation is skill-based and individualized and will be provided to meet the participant's needs as determined by the assessment performed in accordance with Department requirements and as outlined in the participant's service plan.

Habilitation services may help participants develop skills necessary for community living, such as:

- Instruction in accessing and using community resources such as transportation, translation and communication assistance related to a habilitative outcome and services to assist the participant in shopping and other necessary activities of community and civic life, including self-advocacy.
- Instruction in developing or maintaining financial stability and security (e.g., understanding budgets, managing money and the right to manage their own money).

Habilitation provides onsite modeling, training, cueing and/or supervision to assist the participant with a mental health or mental health co-occurring diagnosis in developing maximum independent functioning in community living activities.

As necessary, Habilitation may include assistance in completing activities of daily living and instrumental activities of daily living. This service also includes assistance with medication administration and the performance of health-related tasks to the extent State law permits.

Services must be delivered in a manner that supports the participant's communication needs including, but not limited to, age appropriate communication, translation services for participants that are of limited-English proficiency or who have other communication needs requiring translation, assistance with the provider's understanding and use of communication devices used by the participant.

This service may be delivered in the participant's home or in local, public community environments as described in the service plan, such as libraries or stores.

This service includes implementation of the behavior support plan and, if necessary, the crisis support plan. The service includes collecting and recording the data necessary to support the review of the service plan, the behavior support plan and the crisis support plan, as appropriate. The total combined hours for Habilitation and Residential Supports/Supported Housing are limited to no more than a total of 250 hours in a calendar year.

Residential Supports in Community Settings

Residential Supports services are designed to assist residents with acquiring, retaining and improving the necessary skills needed to live successfully in home and community-based settings. Residential Supports services are necessary, as specified by the service plan, to enable the participant to integrate fully into the community and ensure the health, welfare, safety and maximum independence of the participant. Residential Supports providers will coordinate and ensure access to necessary medical and clinical services. Residential Supports may be provided when the provider of Residential Supports services is also the provider of the housing for the participant.

Residential Supports are skill based and individualized and will be provided to meet the participant's needs as determined by the assessment performed in accordance with Department requirements and as outlined in the participant's service plan.

Residential Supports services may help participants develop skills necessary for community living, such as:

- Instruction in accessing and using community resources such as transportation, translation, and communication assistance as identified as a need in the plan of care and services to assist the participant in shopping and performing other necessary activities of community and civic life, including self-advocacy.
- Instruction in developing or maintaining financial stability and security (e.g., understanding budgets, managing money and the right to manage their own money).

Residential Supports provide onsite modeling, training, and/or supervision to assist the participant in developing maximum independent functioning in community living activities.

The cost of transportation provided by Residential Supports service providers to and from activities is included as a component within the rate of the Residential Supports services and, therefore, is reflected in the rate for the service. Providers of Residential Supports services are responsible for the full range of transportation services needed by the participants they serve to participate in services and activities specified in their service plan. This includes transportation to and from Day Habilitation and employment services, as applicable.

Services must be delivered in a manner that supports the participant's communication needs including, but not limited to, age appropriate communication, translation services for participants that are of limited-English proficiency or who have other communication needs requiring translation, assistance with the provider's understanding and use of communication devices used by the participant. The total combined hours for Habilitation and Residential Supports/Supported Housing are limited to no more than a total of 250 hours in a calendar year. Time limited exceptions to this limit for individuals transitioning from institutions[17] are permitted if prior authorized and found to be part of the cost-effective package of services provided to the individual compared to institutional care.

Respite

Short-term Crisis Respite:

Crisis Respite is a short-term care and intervention strategy for individuals who have a mental health or co-occurring diagnosis and are experiencing challenges in daily life that create imminent risk for an escalation of symptoms that cannot be managed in the person's home environment without onsite supports and/or a loss of adult role functioning. It is for individuals who do not pose a risk to the safety of themselves or others. Crisis respite is provided in site-based residential settings or with staff at the individual's home. It may be used when acutely challenging emotional crisis occur which the individual is unable to manage without intensive assistance and support.

Crisis Respite services may be delivered by peers or para-professionals. Referrals to Crisis Respite may come from the emergency room, the community, self-referrals, or as part of a

[17] Institutions include nursing homes, adult homes, state operated psychiatric centers, and residences on the grounds of psychiatric centers.

step-down plan from an inpatient setting. Services offered may include: site-based crisis residence, peer support, either on site or as a wrap-around service during the respite stay, health and wellness coaching, wrap planning, wellness activities, family support, conflict resolution, and other services as needed. Crisis Respite is not intended as a substitute for permanent housing arrangements.

Ongoing communication between individuals receiving crisis respite, crisis respite staff, and the individuals' established mental health providers is recommended to assure collaboration and continuity in managing the crisis situation and identifying subsequent support and service systems. At the conclusion of a Crisis Respite period, crisis respite staff, together with the individual and his or her established mental health providers, will make a determination as to the continuation of necessary care and make recommendations for modifications to the recipients' plan of care. Participants are encouraged to receive crisis respite in the most integrated and cost-effective settings appropriate to meet their respite needs.

Use of Crisis Respite should be no longer than 1 week per episode, and use of crisis respite by an individual is not to exceed a maximum of 45 days per year. Individual stays of greater than 72 hours require prior authorization. Individuals requiring crisis respite for longer periods than those specified may be evaluated on an individual basis and approved for greater length of stay based on medical necessity.

Intensive Crisis Respite:

Intensive Crisis Respite (ICR) is a short-term, residential care and clinical intervention strategy for individuals who may be a danger to self or others; or have a mental health or co-occurring diagnoses and are experiencing acute escalation of mental health symptoms. Individuals in need of ICR are at imminent risk for loss of functional abilities, and raise safety concerns for themselves and others. The immediate goal of ICR is to provide supports to help the individual stabilize and return to previous level of functioning. This service can be provided as a step-down from inpatient hospitalization, ER diversion, or referral from mobile crisis teams or another clinician. Intensive crisis respite may be provided in clinically staffed, community-based sites. ICR services are primarily delivered by licensed medical and mental health professionals. Services offered may include: comprehensive psychiatric, health, and wellness assessments, individual and group counseling, training in de-escalation strategies, medication management, peer support, WRAP planning, wellness activities, family support, conflict resolution, and other services as needed. Ongoing communication between individuals receiving ICR, crisis respite staff, and the individuals' established mental health providers is necessary to assure collaboration and continuity in managing the crisis, as well as to identify effective subsequent support and service resources. At the conclusion of an Intensive Crisis Respite period, clinical staff, together with the individual, will make recommendations for modifications to the recipients' plan of care. Participants are encouraged to receive respite in the most integrated and cost-effective settings appropriate to meet their respite needs. Use of Intensive Crisis Respite should not exceed a maximum of 45 days per year. Individuals requiring Intensive Crisis Respite for longer periods than those specified may be evaluated on an individual basis and approved for greater length of stay based on medical necessity.

Support Services

Family Support and Training

This service provides the training and support necessary to support and to ensure engagement and active participation of the family in the treatment planning process and with the ongoing implementation and reinforcement of skills learned throughout the treatment process. For purposes of this service, "family" is defined as the persons who live with or provide care to a person served on the waiver, and may include a parent, spouse, children, relatives, foster family, or in-laws. "Family" does not include individuals who are employed to care for the consumer. Training includes instruction about treatment regimens and use of equipment specified in the plan of care, and shall include updates, as necessary, to safely maintain the individual at home. All family support and training must be included in the individual's written plan of care and for the benefit of the Medicaid covered individual. Allowable activities include:

- Training on treatment regimens and use of equipment;
- Assisting the family to provide a safe and supportive environment in the home and community for the individual (e.g., coping with various behavior challenges);
- Development and enhancement of the families specific problem-solving skills, coping mechanisms, and strategies for the individuals symptom/behavior management;
- Collaboration with the family and caregivers in order to develop positive interventions to address specific presenting issues and to develop and maintain healthy, stable relationships among all caregivers, including family members, in order to support the participant. Emphasis is placed on the acquisition of coping skills by building upon family strengths;
- Assisting the family in the acquisition of knowledge and skills necessary to understand and address the specific needs of the Medicaid eligible individual in relation to their mental illness and treatment;
- Assisting the family in understanding various requirements of the waiver process, such as the crisis/safety plan and plan of care process; training on understanding the individual's diagnoses; understanding service options offered by service providers; and assisting with understanding policies, procedures and regulations that impact the individual with mental illness/addictive disorder concerns while living in the community (e.g., training on system navigation and Medicaid interaction with other individual-serving systems);
- Training on community integration;
- Training on behavioral intervention strategies;
- Training on mental health conditions, services and supports;

- Training and technical assistance on caring for medically fragile individuals.

The total combined hours for Family Support and Training are limited to no more than a total of 30 hours in a calendar year.

Non-Medical Transportation

Non-medical Transportation services are offered, in addition to any medical transportation furnished under the 42 CFR 440.17(a) in the State Plan. Non-medical Transportation services are necessary, as specified by the service plan, to enable participants to gain access to authorized home and community based services that enable them to integrate more fully into the community and ensure the health, welfare, and safety of the participant.

This service will be provided to meet the participant's needs as determined by an assessment performed in accordance with Department requirements and as outlined in the participant's service plan.

Transportation services consist of:

- Transportation (Mile)

  This Transportation service is delivered by providers, family members, and other qualified, licensed drivers. Transportation (Mile) is used to reimburse the owner of the vehicle or other qualified, licensed driver who transports the participant to and from services and resources related to outcomes specified in the participant's service plan. The unit of service is one mile. Mileage can be paid round trip. A round trip is defined as from the point of first pickup to the service destination and the return distance to the point of origin.

  When Transportation (Mile) is provided to more than one participant at a time, the provider will divide the shared miles equitably among the participants to whom Transportation is provided. The provider is required (or it is the legal employer's responsibility under the Vendor Fiscal/Employer Agent (FMS) model) to track mileage, allocate a portion to each participant, and provide that information to the Case Manager for inclusion in the participant's service plan.

  Services must be delivered in a manner that supports the participant's communication needs including, but not limited to, age appropriate communication, translation services for participants that are of limited-English proficiency or who have other communication needs requiring translation, assistance with the provider's understanding and use of communication devices used by the participant.

- Public Transportation

  The utilization of Public Transportation promotes self-determination and is made available to participants as a cost-effective means of accessing services and activities. This service provides payment for the individual's use of public transportation.

The Case Manager will monitor this service quarterly and will provide ongoing assistance to the participant to identify alternative community-based sources of transportation. Consistent with other HCBS authorities in New York, all other options for transportation, such as informal supports, community services and public transportation, must be explored and utilized prior to

requesting non-medical transportation. Individuals enrolled in residential services who receive transportation as part of the benefit will not be eligible for this 1915(i)-like service. Non-medical transportation is limited to no more than $2,000 per calendar year.

Individual Employment Support Services

Individual employment support services are individualized, person-centered services providing supports to participants who need ongoing support to learn a new job and maintain a job in a competitive employment or self-employment arrangement. Participants in a competitive employment arrangement receiving Individual Employment Support Services are compensated at or above the minimum wage and receive not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. The outcome of this activity is documentation of the participant's stated career objective and a career plan used to guide individual employment support.

For all employment supports services, documentation is maintained in the file of each individual receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.). Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses, such as the following: incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program, payments that are passed through to users of supported employment programs, and payments for training that is not directly related to an individual's supported employment program. When employment support services are provided at a work site where persons without disabilities are employed, payment is made only for the adaptations, supervision, and training required by participants receiving waiver services as a result of their disabilities but does not include payment for the supervisory activities rendered as a normal part of the business setting.

Services include:

Pre-vocational: Time-limited Services that prepare a participant for paid or unpaid employment. Services that provide learning and work experiences where the individual can develop general, non-job-task-specific strengths and skills that contribute to employability in paid employment in integrated community settings. Services are expected to occur over a defined period of time and with specific outcomes to be achieved, as determined by the individual and his/her service and supports planning team through an ongoing person-centered planning process.

Services include:

- Teaching such concepts as compliance, attendance, task completion, problem solving, and safety.
- Providing scheduled activities outside of an individual's home that support acquisition, retention, or improvement in job-related skills related to self-care, sensory-motor development, socialization, daily living skills, communication, community living, social and cognitive skills.
- Gaining work-related experience considered crucial for job placement (e.g., time-limited unpaid internship).

Services do not include:

- Job-task oriented, but instead, are aimed at a generalized result.

Documentation is maintained that the service is not available under a program funded under Section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.).

The total combined hours for pre-vocational and transitional, supported employment) are limited to no more than a total of 250 hours and a duration of 9 months of service in a calendar year.

Transitional Employment: Services that strengthen the participant's work record and work skills toward the goal of achieving assisted or unassisted competitive employment at or above the minimum wage paid by the competitive sector employer. This service is provided, instead of individual supported employment, only when the person specifically chooses this service and may only be provided by clubhouse or psychosocial club program.

Services include:

- Providing time-limited employment and on-the-job training in one or more integrated employment settings as an integral part of the individual's vocational rehabilitation growth.
- Providing support to participants to gain skills to enable transition to integrated, competitive employment.
- Training activities provided in regular business, industry, and community settings.
- Promoting integration into the workplace and interaction between participants and people without disabilities in those workplaces.
- Providing on the job supports, initial and ongoing employment planning and advancement, employment assessment not otherwise covered in the annual career planning, job placement, job development, negotiation with prospective employers, job analysis, training and systematic instruction, job coaching, benefits supports, training, and planning transportation.
- Providing services not specifically related to job skill training that enable the waiver participant to be successful in integrating in to the job setting.

The total combined hours for pre-vocational and transitional, supported employment) are limited to no more than a total of 250 hours and a duration of 9 months of service in a calendar year.

Intensive Supported Employment: Services that consist of intensive supports that enable participants for whom competitive employment at or above the minimum wage is unlikely, absent the provision of supports, and who, because of their disabilities, need supports to perform in a regular work setting.

Services include:

- Assisting the participant to locate a job or develop a job on behalf of the participant via the use of individualized placement and support services that include rapid job search.

- Supporting the participant to establish or maintain self-employment, including home-based self-employment.
- Providing ongoing vocational/job-related discovery or assessment
- Providing job placement, job development, job coaching, negotiation with prospective employers, job analysis, job carving, training and systematic instruction, benefits counseling support, training and planning, transportation, asset development and career advancement services, and other workforce support services.

The ongoing level of care criteria including service duration, intensity and effectiveness should be reviewed by the 1915(i) care manager and/or the MCO at least quarterly.

Ongoing Supported Employment: is conducted after a participant successfully obtains and becomes oriented to competitive and integrated employment. Ongoing follow-along is support available for an indefinite period as needed by the participant to maintain their paid employment position.

Services include:

- Providing support in a variety of settings, particularly work sites where persons without disabilities are employed.
- Providing activities needed to sustain paid work by participants, including supervision and training.
- Providing reminders of effective workplace practices and reinforcement of skills gained during the period of intensive supported employment services.

Education Support Services

Education Support Services consist of special education and related services as defined in Sections (22) and (25) of the Individuals with Disabilities Education Improvement Act of 2004 (IDEA) (20 U.S.C. 1401 et seq.), to the extent to which they are not available under a program funded by IDEA or available for funding by the Office of Vocational Rehabilitation (OVR). Education Support Services may consist of general adult educational services including community college, university or other college-level courses, classes, tutoring to receive a Test Assessing Secondary Completion (TASC) diploma, and support to the participant to participate in an apprenticeship program. Participants authorized for Education Support Services must have an employment outcome or an outcome related to skill attainment or development which is documented in the service plan and is related to the Education Support Service need. Education Support services must be specified in the service plan as necessary to enable the participant to integrate more fully into the community and to ensure the health, welfare and safety of the participant. Documentation is maintained in the file of each individual receiving this service that the service is not otherwise available under section 110 of the Rehabilitation Act of 1973 or the IDEA.

Ongoing Supported Education: is conducted after a participant is successfully admitted to an educational program. Ongoing follow-along is support available for an indefinite period as needed by the participant to maintain their status as a registered student.

Services include:

- Providing support in a variety of educational settings, such as classroom and test-taking environments.
- Providing cognitive remediation services to improve executive functioning abilities such as attention, organizing, planning and working memory.
- Providing advocacy support to obtain accommodations such as requesting extensions for assignments and different test-taking environments.

The hours for supported education are limited to no more than a total of 250 hours per year.

Self-Directed Services

Under self-directed Medicaid services, participants, or their representatives, if applicable, have employer and/or budget decision-making authority over certain services and take direct responsibility to manage their services with the assistance of a system of available supports. The self-directed service delivery model is an alternative to traditionally delivered and managed services where providers control hiring, supervision, and wages, such as an agency delivery model. Self-direction of services allows participants to have the responsibility for managing all aspects of service delivery within the context of a person-centered planning process.

Self-direction promotes personal choice and control over the delivery of waiver and state plan services, including who provides the services and how services are provided. Participants have both employer authority and budget authority. Employer authority affords participants the decision-making authority to recruit, hire, train and supervise the individuals who provide their services. Budget authority allows participants to have decision-making authority over how the Medicaid funds in a budget are spent such as wages paid and the number of hours worked.

New York will be piloting self-direction of care in the behavioral health area for the first three years of this demonstration amendment. The self-directed pilot will include the following elements:

- Person-centered planning process: The person and any collateral supports he or she identifies develop a plan that identifies the person's strengths, capacities, preferences, needs, and goals/outcomes. This plan should include contingency planning & an assessment of risks.
- Development of a service plan: The service plan describes the services and supports the person will use to meet the goals/outcomes he or she has identified in the person-centered plan.
- Individualized budget: Defines the amount of funds the person will control as part of the self-directed option. The method for calculating the scope of individual budgets is determined by the individual state offering the self-directed option.
- Information and awareness in support of self-direction: Supports must be in place that are designed to assist the individual in developing the plan, managing the plan,

understanding how self-direction works, self-direction-specific supports such as a support broker and/or financial management services.

- Quality Assurance & Improvement: There must be a mechanism in place that provides continuous quality assurance and improvement, including monitoring and responding to serious incidents and monitoring performance measures and individual outcomes.

The following supports and services will be available to participants in the self-direction pilot:

- Support Broker Services: Medicaid requires that a support broker or counselor be available to assist in development, implementation, and monitoring of the self-directed services. The support broker is considered “an agent” of the individual and takes direction from the individual.
- Fiscal Management Services (FMS): FMS assists individuals with exercising budget authority. This is not a requirement but individuals often prefer to use the FMS for assistance with understanding billing and documentation, performing payroll and employer-related duties, purchasing approved goods & services, tracking and monitoring expenditures.

Attachment D: MCO and HARP Staffing Grid

Section 3.3	Position/Role	Dedicated to product line(s)?	Can Plan propose to share across MCO and HARP?	Must be full-time?	NYS Location	Requirements
Key Personnel with Notification Requirements						
Plans must designate one of the key personnel positions to have overall accountability for the 1) Qualified Mainstream Plan product line and 2) (if offered) the HARP product line						
Bi.	Behavioral Health Medical Director(s)	Yes, Qualified Mainstream Plan and HARP	Yes	Yes	Yes	• NYS license as a physician. • Minimum 5 years BH managed care (MC) or clinical experience in both psychiatry and addiction disorders. • If MCO does not offer HARP product line, it is likely the MCO will have to hire 2 part-time positions to cover psychiatry and addictions expertise. • If MCO has HARP product line, Plan must also have HARP Medical Director (see below HARP Key Personnel). One of these positions must be boarded in psychiatry and the other must have addictions certification.
B.ii	Behavioral Health Clinical Director	Yes, BH MCO	No	Yes if Plan does not offer HARP product line	Yes	• NYS license as BHP • Seven years experience in BH MC or BH clinical setting including at least 2 years of MC experience (preferably Medicaid MC).
Required Managerial Personnel						
D.i	BH UM/CM	Yes, BH MCO and HARP	Yes	No	Yes	• BHP • BH MC or BH clinical experience. • Large plans will need to describe adequate supervisory resources.

Section 3.3	Position/Role	Dedicated to product line(s)?	Can Plan propose to share across MCO and HARP?	Must be full-time?	NYS Location	Requirements
D.ii	BH network development	No	Yes	No	Yes	• Experience in BH MC or BH clinical setting. • Expertise in BH network development and target populations. • Familiar with recovery-oriented services.
D.iii	BH provider relations	No	Yes	No	Yes	• Experience in BH MC or BH clinical setting. • Expertise in target populations, recovery principles, EBPs. • Familiar with recovery-oriented services.
D.iv	BH training	No	Yes	No	No	• Significant experience and expertise in training related to BH systems. • Familiar with recovery-oriented services.
D.v	BH QM	No	Yes	No	Yes	• Experience and expertise in QI, public sector MH/addictions programs/delivery systems. • Familiar with recovery-oriented services.
D.vi	BH information systems	No	Yes	No	Yes	• Experience and expertise in Medicaid and BH data analytics/systems.
D.vii	Governmental/ community liaison	No	Yes	No	Yes	• Must be individual with significant plan leadership responsibilities.

Section 3.3	Position/Role	Dedicated to product line(s)?	Can Plan propose to share across MCO and HARP?	Must be full-time?	NYS Location	Requirements
Other Personnel						
E.i	UM/CM	No	Yes	No	Yes	• 7-day availability. • US licensed BHP. • CASACs (must also be U.S. licensed BHPs) for SUD reviews. • Experience in managing target populations. • Authorization decisions by US BHP with minimum three years of experience in a BH setting. • Enhanced requirements HARP: – Experience and knowledge with 1915i services, recovery, EBPs.
E.ii	Clinical Peer Reviewers	No	Yes	No	No	• Includes panel of physicians who hold board certified in general psychiatry and certification in addiction medicine or subspecialty in addiction psychiatry and licensed doctoral level psychologists.
E.iii	BH QM specialists	No	Yes	No	Yes	• Would be same as MCO; must have relevant regulatory, QM, managed care or clinical BH experience and may include licensed BHPs and CASACs.
E.iv	Provider relations	No	Yes	No	Yes	• Would be same as MCO. • MCOs located in NYC must locate some staff in NYC.

Section 3.3	Position/Role	Dedicated to product line(s)?	Can Plan propose to share across MCO and HARP?	Must be full-time?	NYS Location	Requirements
HARP Key Personnel						
J.i	HARP Medical Director, Behavioral Health	Yes, BH MCO and HARP	Yes	Yes	Yes	• NYS licensed physician. • Minimum 5 years BH MC or clinical experience in both psychiatry and addiction disorders. • See above requirements for BH Medical Director. Re Qualified Mainstream Plan and HARP Medical Directors: If one is boarded in psychiatry, the other must have addictions certification.
J.ii	HARP Medical Director, General Medicine	Yes, BH MCO and HARP	Yes	No	Yes	• NYS licensed physician. • Board certified in general medicine or family practice. • Minimum 5 years of experience in MC setting or clinical setting, with at least 2 years clinical experience.
J.iii	HARP Clinical Director	Yes, BH MCO and HARP	Yes	Yes	Yes	• NYS licensed BHP. • Seven years of experience in BH MC or BH clinical setting including at least 2 years of MC experience (preferably Medicaid MC). • HARP Clinical Director could serve as MCO BH Clinical Director for smaller plans.

Section 3.3	Position/Role	Dedicated to product line(s)?	Can Plan propose to share across MCO and HARP?	Must be full-time?	NYS Location	Requirements
Additional HARP Personnel						
K.i	HARP HCBS Administrator	Yes, HARP	No	No	Yes	• Knowledge of HCBS. • Familiarity with HCBS requirements. • Prefer three years of experience SMI, SUD, co-occurring SMI/SUD. • Experience working in a NYS behavioral health setting that provides recovery-oriented services to individuals with serious mental illness or serious substance use disorders.
K.ii	HARP Addictions Administrator	No	Yes	No	Yes	• Master's degree and meets requirements for CASAC. • Three years of experience and expertise with SUD with or without co-occurring mental illness. • Prefer experience with EBPs.
K.iii	HARP UM/CM	Yes, HARP	No	No	Yes	• Experience and knowledge with BH rehabilitation programs, supported housing, supported employment, vocational rehabilitation resources, and welfare to work programs. • Experience should include knowledge of recovery-oriented practices and development of EBPs as recognized by the SAMHSA and other national registries for these populations. • Among other topics, training will be required in HCBS requirements, supportive housing and services for individuals with FEP.

Attachment E: HCBS Reporting System IT Requirements Necessary to Meet Federal Assurances and Sub-Assurances in Attachment B

These information systems requirements are typical for health plans to document compliance with the home and community-based assurances and sub-assurances in Attachment B. These requirements are based on experience with other states and are typical of the level of detail needed to calculate the metrics and formulas for demonstrating compliance with these assurances and sub-assurances. The State will negotiate the metrics and calculation of those metrics with CMS and work with Plans to streamline all requirements including any information system technology requirements associated with the quality assurance requirements.

A. **Report capability**: The System will be able to document and create reports needed for program administration and required federal HCBS reporting (see Attachment B) including:
   I. Document HCBS services delivery by provider, service, and individual.
   II. Document and track monthly service units delivered by providers.
   III. Document quality indicator data submitted by providers.
   IV. Conduct trend analyses on HCBS indicators.
   V. Generate standardized HCBS reports in a timely manner.
   VI. Capability to generate tailored provider reports (including Care Managers in Health Homes).
   VII. Reports may consist of, but are not limited to, data such as:
      a. Number of individuals receiving services in a particular county or region.
      b. Assessments performed timely by health homes.
      c. Timely development of Recovery Plans, amendments, and renewals.
      d. Corrective Action Plans required of providers and implemented timely
      e. Number of individuals receiving specific services.
      f. Claims/Financial report capability that document allocated funds and expended funds for Medicaid HCBS services.
      g. Monthly service monitoring reports for Health Home Care Manager to utilize for monitoring.

B. **Evaluation process** – All individuals in the HARP will be evaluated for eligibility for 1915(i)-like services. Individuals for whom it is believed that they will be eligible for the 1915(i)-like services will receive a conflict-free evaluation/assessment from an appropriately qualified individual, using a standardized clinical and functional assessment tool consistent with the State's approved Balancing Incentive Payment Program. The evaluation and assessment will be combined whenever possible. Individuals meeting one of the needs-based criteria

identified below, which are less stringent than HCBS institutional levels of care, will be eligible for 1915-like services.

l. The Intake data should include the following:

a. Date of initial evaluation for 1915(i)-like Services. This section includes the capability of additional evaluations for 1915(i)-like eligibility for people who have been evaluated and not found eligible in the past. Note: dates for each completed step should be recorded in a manner that permits quality review (i.e., no back-dating allowed).

b. Demographic Information - The system has limited user levels for in-putting information onto a primary demographic section of the system, i.e., Medicaid number and the individual's name as it appears on the Medicaid Plan roster should auto-fill.

c. Outcome and date of 1915(i)-like evaluation.

d. Date that individual is determined eligible or ineligible for 1915(i)-like services including any notification to individual (e.g.. eligibility letter is sent or notice of action/due process letter is sent for denial).

e. When the individual is approved for 1915(i) like services, the date of the face-to-face meeting to complete a needs assessment (if completed separated from the 1915(i) eligibility evaluation).

f. Results and date of completed needs assessment.

g. Identification and qualifications of assessors.

h. Ability to input information on assessment results including documentation and notes.

i. Date and notes of any Care Manager contacts with individual/ family during the evaluation and assessment process.

j. Ability to record referral and date of referral for second eligibility/assessment review (if necessary).

k. Ability to enter second review, documentation, dates and results (if necessary).

l. For eligibility denials, applications are archived for future reference in the event of an application resubmittal.

m. Date, comment section, and signature field in the event of an eligibility decision appeal.

n. Signatures by the following: individual, assessment clinician, physician, other clinician review, and dates of coverage.

o. Auto generated email when assessments are at a certain level or the individual is a certain age to the appropriate assessor (i.e., if there are

Transition Age Youth, children with history in the children's MH system, or First Episode Psychosis).

p. Include an alert system to notify Care Managers on required upcoming annual assessment and completion of the assessments as well as needed Recovery Plan updates.

C. Recovery Plan Development – The system should have the following capabilities to track the following information:

I. Date of the individual's Recovery Plan development meeting.

II. Date the plan is updated (as needed) and at least annually.

III. Changes in the resource allocation (i.e., budget) that the individual receives.

IV. Generate and house individual resource allocations associated with Recovery Plans. Compute funding amounts based on units, unit rate and annualized unit information for annual costs for each Recovery Plan.

I. Document the participants (all providers, the consumer, and the care manager in the health home) developing the Recovery Plan and record signatures or uploads of signature pages.

V. Designated users have the ability to create and modify prior authorizations using the approved Recovery Plan to send to the Plan's claims management system. The system should ensure that once the Recovery Plan or any subsequent modifications are approved, it becomes the prior authorization.

VI. Additional, viewer only access, to designated care managers, Plan staff and designated providers to view Recovery Plans.

VII. Fully interface with and create reports of HCBS services utilization integrated with acute care services utilization for individual HARP members in a manner that allows client specific reports on services utilized and paid.

D. Recovery Plan Data Elements – The system would have the following capabilities to allow Care Managers and Utilization Management to readily manage the Recovery Plan elements:

II. Due to the linkage between the Assessment/Evaluation and the Recovery Plan, the data system should pre-populate fields where possible (e.g., personal profile, health and safety, and assessed needs).

III. Track and distinguish changes in the annual Recovery Plan from previous Recovery Plan language.

IV. Allow modifications of each Recovery Plan as needed (e.g., adding goals, person centered description, modifying service amount, duration and scope, etc.).

V. Creating and housing more than one Recovery Plan or assessment each year

VI. Automatically generate a Recovery Plan resource allocation for each individual and reflect any changes to the individual's budget during the year.

VII. Track the date the Care Manager completes Recovery Plan and submits for approval to UM and whether or not the Recovery Plan is submitted timely.

VIII. Track the date of UM approval or the date UM sends the Recovery Plan back to the Care Manager for further documentation. Track the date the UM approves the Recovery plan and whether or not UM review is completed timely. Incorporate any documentation by UM for approval of the Recovery Plan.

IX. Track the approval date, comments and routing to individuals for any prior authorizations required for specific HCBS services on the Recovery Plan. Track the date, content and disposition of further review (e.g., information from UM Physician).

X. Track the date of Notice of Action if care is denied or limited.

XI. Notification to providers and to the Care managers for Recovery Plan completions, as well as, changes, indicating approval or non-approval.

XII. When a Recovery Plan is rejected, a notice to the Care manager and providers. All rejections and why Recovery Plans are rejected must be tracked until the Recovery Plan is approved.

XIII. Capture information regarding Recovery Plans for individuals with participant directed services or a way to designate within each individual's demographics to highlight those enrolled in participant direction:

a. Information related to those receiving participant direction, will include the individuals' contact information, report capabilities, analysis trending capabilities, family hiring/approvals information, an approved co-employer provider listing and the services they are approved to provide.

b. A linkage to third party billing sites if the Plan does not provide the Fiscal Management Services directly under participant direction. (used to upload approved Prior Authorizations for participant direction).

E. Referral and Monitoring Activities of Health Home Care Managers – The MCO will require documentation of required HCBS Health Home Care Manager activities (e.g., dates of visits, conclusion of the visit, narrative of visit, notifications if quality of care concern)

I. The MCO will require Health Home Care Manager documentation of CM Monitoring visits to be maintained. The documentation should at a minimum:

a. Permit multiple users including the specific Health Home Care Manager and Supervisor within the Health Home supporting the individual to access documentation of a Care Manager visit.

b. Be available to the Plan care management and UM staff supporting the individual.

c. Track start and end times of visits.

d. Track health and welfare of individuals, especially those being discharged or transitioning from an institution such as a state hospital.

e. Track information from the site visit in key fields.

f. At the Plan's option, any Care Manager finding Health and Welfare concerns will document the visit through a CM Monitoring Report that requires a Corrective Action Plan. The MCO will notify the service provider of the adverse report requesting that the service provider develop a Corrective Action Plan.

II. The MCO will maintain additional documentation for MCO UM staff to have additional narratives for 1915(i) members including discharged individuals in addition to regular Recovery Plan referral and monitoring process through Health Home Care Managers

III. The MCO will have the capability to track all Corrective Action Plans by affected provider or by Health Home Care Manager.

IV. Key fields from the Corrective Action Plans can be uploaded into the MCO data management system.

V. The MCO will track any appeal of a Corrective Action Plan and document any changes as a result of such appeals.

VI. The MCO will create provider trend reports based on Health Home Care Manager monitoring.

VII. The MCO will allow users to upload upload key data fields from documents such as assessments. If necessary, the MCO allows Health Home Care Managers to upload documents with key fields so these documents can be searchable.

F. The System will maintain Provider qualification data (e.g., credentialing files) to support HCBS reporting including documenting provider specific data including but not limited to service capacity, utilization, and performance. The data base should include all active HCBS Medicaid providers and the services they are qualified to perform. This information may be housed with other provider information as long as HCBS service specific provider reporting can be generated. Information will include at a minimum:

I. A list of all HCBS providers with their contact information, active Medicaid numbers and tax IDs, with all authorized services.

II. Provider qualification information including provider license and license expiration information if applicable.

III. The capability to store inactive provider numbers separately from the active provider numbers.

IV. Ability to report on provider capacity including ability to track and maintain site-specific, service capacity for approved HCBS services location.