



Department of Health

Request for Proposals

RFP # 20024

Independent Evaluation of the New York State (NYS) Health and Recovery Plans (HARP) Program and Self-Directed Care (SDC) Pilot Program

Issued: January 31, 2019
Modified February 28, 2019

DESIGNATED CONTACT:

Pursuant to State Finance Law §§ 139-j and 139-k, the Department of Health identifies the following designated contact to whom all communications attempting to influence the Department of Health's conduct or decision regarding this procurement must be made.

Elizabeth Wood
Bureau of Contracts
New York State Department of Health
Corning Tower, Room 2827
Albany, New York 12237
Telephone: 518-474-7896
Email Address: elizabeth.wood@health.ny.gov

PERMISSIBLE SUBJECT MATTER CONTACT:

Pursuant to State Finance Law § 139-j(3)(a), the Department of Health identifies the following allowable contact for communications related to the submission of written proposals, written questions, pre-bid questions, and debriefings.

Jay Cooper
New York State Department of Health
Office of Quality and Patient Safety
Corning Tower, Room 2084
Albany, New York 12237
Telephone: 518-473-8291
Email Address: OQPS.ASU@health.ny.gov

TABLE OF CONTENTS

1.0 CALENDAR OF EVENTS.....3

2.0 OVERVIEW3

 2.1 Introductory Background..... 3

 2.2 Important Information..... 4

 2.3 Term of the Agreement..... 5

3.0 BIDDERS QUALIFICATIONS TO PROPOSE.....5

 3.1 Minimum Qualifications..... 5

4.0 SCOPE OF WORK6

 4.1 Tasks/Deliverables 8

 4.2 Staffing Requirements 48

 4.3 Reporting Requirement..... 49

 4.4 Information Technology 49

 4.5 Security 49

 4.6 Transition 50

5.0 ADMINISTRATIVE INFORMATION 50

 5.1 Restricted Period 50

 5.2 Questions..... 50

 5.3 Letter of Intent to Bid 51

 5.4 Right to Modify RFP..... 51

 5.5 Payment..... 51

 5.6 Minority & Woman-Owned Business Enterprise Requirements 52

 5.7 Equal Employment Opportunity (EEO) Reporting 53

 5.8 Sales and Compensating Use Tax Certification (Tax Law, § 5-a) 54

 5.9 Contract Insurance Requirements..... 54

 5.10 Subcontracting..... 54

 5.11 DOH’s Reserved Rights..... 55

 5.12 Freedom of Information Law (“FOIL”)..... 55

 5.13 Lobbying 55

 5.14 State Finance Law Consultant Disclosure Provisions 56

 5.15 Debriefing 56

 5.16 Protest Procedures..... 57

 5.17 Iran Divestment Act 57

 5.18 Piggybacking 57

 5.19 Encouraging Use of New York Businesses in Contract Performance..... 57

 5.20 Diversity Practices Questionnaire..... 57

 5.21 Participation Opportunities for NYS Certified Service-Disabled Veteran-Owned Businesses . 57

 5.22 Intellectual Property..... 58

 5.23 Vendor Assurance of No Conflict of Interest or Detrimental Effect 58

 5.23 Executive Order 177 Prohibiting Contracts with Entities that Support Discrimination..... 58

6.0 PROPOSAL CONTENT 58

 6.1 Administrative Proposal 59

 6.2 Technical Proposal 60

 6.3 Cost Proposal 63

7.0 PROPOSAL SUBMISSION 63

 7.1 No Bid Form..... 64

8.0 METHOD OF AWARD..... 64

 8.1 General Information 64

 8.2 Submission Review 65

 8.3 Technical Evaluation..... 65

 8.4 Cost Evaluation..... 65

 8.5 Composite Score 65

 8.6 Reference Checks 66

 8.7 Best and Final Offers 66

 8.8 Award Recommendation 66

ATTACHMENTS..... 66

1.0 CALENDAR OF EVENTS

RFP # 20024 - INDEPENDENT EVALUATION OF THE NEW YORK STATE (NYS) HEALTH AND RECOVERY PLANS (HARP) PROGRAM AND SELF-DIRECTED CARE (SDC) PILOT PROGRAM	
<u>EVENT</u>	<u>DATE</u>
Issuance of Request for Proposals	January 31, 2019
Deadline for Submission of Written Questions	February 22, 2019 5:00 p.m. ET
<u>Deadline for 2nd Round for Submission of Written Questions</u>	<u>March 8, 2019</u> 5:00 p.m. ET
Responses to <u>All</u> Written Questions Posted by DOH	On or About March 1, 2019 <u>March 15, 2019</u>
Letter of Intent to Bid (Optional, See Section 5.3)	March 8, 2019 <u>March 22, 2019</u>
Deadline for Submission of Proposals	March 29, 2019 <u>April 5, 2019</u> 5:00 p.m. ET
<u>Anticipated</u> Contract Start Date	August 1, 2019

2.0 OVERVIEW

Through this Request for Proposals (“RFP”), the New York State (“State”) Department of Health (“DOH”) is seeking competitive proposals from an independent evaluator to provide services as further detailed in [Section 4.0](#) (Scope of Work). It is the Department’s intent to award one (1) contract from this procurement.

2.1 Introductory Background

Health and Recovery Plans (HARPs)

In 2015, the State amended its 1115 Waiver to enable qualified Managed Care Organizations (MCOs) throughout New York State (NYS) to comprehensively manage behavioral health (BH) benefits for eligible recipients. These benefits will be met in the following ways:

- Mainstream Medicaid Managed Care (MMC) Plans:
- All adult recipients who are eligible for MMC (excludes Medicare recipients and certain other populations) receive the full medical and BH benefit through managed care. Plans began to cover expanded BH benefits on October 1, 2015. The expanded benefit includes services which the MMC plans previously managed for the non-Supplemental Security Income (SSI) population (psychiatric inpatient and psychiatric clinic services), services that were covered only via the Medicaid Fee for Service (FFS) program, and new services. Also, effective October 1, 2015, consumers enrolled in MMC whose BH benefit was covered under FFS Medicaid through SSI began receiving these benefits through the MMC plan.
- HARPs and Human Immunodeficiency Virus (HIV) Special Needs Plans (SNPs):
- Adults enrolled in Medicaid and 21 years or older meeting the serious mental illness (SMI) and/or Substance Use Disorder (SUD) targeting criteria and risk factors (see Attachment C) were passively enrolled into HARPs following the same timeline as the MMC BH integration. These specialty lines of business operated by the qualified mainstream MCOs (Mainstream MMC) are available statewide. Individuals meeting the HARP eligibility criteria who are already enrolled in an HIV SNP may remain enrolled in their current plan, but received the enhanced benefits of a HARP. Please note that, although not encouraged, a HARP-identified individual may dis-enroll from an HIV SNP into a HARP; this, however, would mean the individual would lose

the HIV SNP benefits. The HARPs and HIV SNPs arrange for access to a benefit package of Home and Community Based Services (HCBS) for members who meet defined functional needs criteria. The HARPs and HIV SNPs work with Health Homes, or other State-designated entities, to develop a person-centered care plan and provide care management for all services with the care plan, including HCBS.

The BH demonstration was phased in with New York City (NYC) transitioning in October 2015 and the Rest of the State (ROS) in July 2016 for adult enrollees (ages 21 to 64). The BH HCBS began to be offered in January 2016 in NYC and in October 2016 for ROS. The aims of the NYS BH demonstration are to improve the NYS Medicaid BH population's health care quality, costs, and outcomes, and to realize transformation of the BH system from an inpatient focused system to a recovery focused outpatient system.

Self-Directed Care (SDC) Pilot

Included under the 1115 waiver demonstration is a pilot program of SDC for individuals with BH needs. The SDC provides the authority to the individual to use public dollars to purchase services and/or to employ service providers. By providing greater autonomy and choice, SDC can more flexibly match the needs of individuals for health care and related services. The ultimate goal of a better match between individual needs and services is to enhance progress toward recovery goals, and improve health and stability in the community. The goal of the SDC pilot is to demonstrate the efficacy and viability of SDC in NYS as a precursor to a statewide implementation.

The pilot program offers opportunities for self-direction in terms of service choice and payment for individuals in NYS who are eligible for the HARP benefit package and BH HCBS. Two (2) agencies, one in NYC and one outside of NYC, have been chosen as sites for the SDC pilot. Additional sites may be added. The agencies are responsible for recruiting and enrolling participants. The expected number of participants is 200 HARP-enrolled and HCBS-eligible individuals for the two (2) sites, but may increase to 600 as additional sites are added. Each SDC participant selects a support broker who works with the individual to identify recovery goals and assists in the creation and implementation of a budget to purchase those goods and services required to meet the recovery goals. Support brokers are hired, trained, and supervised at the participating agency sites. Support brokers work with a fiscal intermediary who provides training, support, and monitoring for the authorization and purchasing of goods and services.

2.2 Important Information

The bidder is required to review, and is requested to have legal counsel review, Attachment 8, the DOH Agreement as the Bidder must be willing to enter into an Agreement substantially in accordance with the terms of Attachment 8 should the bidder be selected for contract award. Please note that this RFP and the awarded bidder's proposal will become part of the contract as Appendix B and C, respectively.

It should be noted that Appendix A of Attachment 8, "Standard Clauses for New York State Contracts", contains important information related to the contract to be entered into as a result of this RFP and will be incorporated, without change or amendment, into the contract entered into between DOH and the successful Bidder. By submitting a response to the RFP, the Bidder agrees to comply with all the provisions of Appendix A.

Note, Attachment 7, the Bidder's Certifications/Acknowledgements, should be submitted and includes a statement that the bidder accepts, without any added conditions, qualifications or exceptions, the contract terms and conditions contained in this RFP including any exhibits and attachments. It also includes a statement that the bidder acknowledges that, should any alternative proposals or extraneous terms be submitted with the proposal, such alternate proposals or extraneous terms will not be evaluated by the DOH.

Any qualifications or exceptions proposed by a bidder to this RFP should be submitted in writing using the process set forth in Section 5.2 (Questions) prior to the deadline for submission of written questions indicated in Section 1.0 (Calendar of Events). Any amendments DOH makes to the RFP as a result of questions and answers will be publicized on the DOH web site.

2.3 Term of the Agreement

The term of the agreement will be for a period of 14 months commencing on the date shown on the Calendar of Events in Section 1.0. After the initial contract term expires, at the discretion of DOH, the contract may be extended, at the same rates, for up to one (1) additional 12-month period by amendment signed by both parties with all required approvals.

3.0 BIDDERS QUALIFICATIONS TO PROPOSE

3.1 Minimum Qualifications

NYSDOH will accept proposals from organizations with the following types and levels of experience as a prime contractor.

- A minimum of three (3) years' experience conducting large-scale (at least one million lives), multi-year program evaluations, including completion of at least one such large-scale (at least one million lives), multi-year program evaluation;
- A minimum of three (3) years of experience performing statistical analyses using claims and encounter data;
- A minimum of three (3) years of experience performing each of the following:
 - statewide or Centers for Medicare and Medicaid Services (CMS) designated Medicaid region comparisons,
 - longitudinal evaluations, and
 - collecting and analyzing qualitative and quantitative data.
- At the time of bid, the bidder and any proposed subcontractors must attest to not having any direct business relationship with any of the MMC plans, and any of the HARP, HIV SNP, and SDC pilot site agencies. The prime contractor and any subcontractors utilized must continue to refrain from any direct business relationship with the MMC plans, and HARP, HIV SNP, and SDC pilot site agencies for the duration of the contract. The Managed Care Organization Directory by Plan (which includes links to HARPs and HIV SNPs) can be found at: https://www.health.ny.gov/health_care/managed_care/plans/mcp_dir_by_plan.htm and SDC pilot site agencies are Community Access, Inc. in New York City and Independent Living, Inc. in Newburgh.

If a bidder or any proposed subcontractors has a direct business relationship, the bidder may propose an operational and information firewall that would eliminate the likelihood of any conflict of interest. At the time of bid, if an operational and information firewall is proposed, the bidder and any proposed subcontractors must attest that the firewall will be established prior to commencement of work and will provide for an independent and unbiased evaluation without the influence of any MMC plans or any of the HARP, HIV SNP, and SDC pilot site agencies.

Experience acquired concurrently is considered acceptable.

For the purposes of this RFP, a prime contractor is defined as one who has the contract with the owner of a project or job and has full responsibility for its completion. A prime contractor undertakes to perform a complete contract and may employ (and manage) one or more subcontractors to carry out specific parts of the contract.

Failure to meet these Minimum Qualifications will result in a proposal being found non-responsive and eliminated from consideration.

4.0 SCOPE OF WORK

Frequently Used Acronyms:

<u>Acronym</u>	<u>Definition</u>
ACT	Assertive Community Treatment
ANOVA	Analysis of Variance
AOT	Assisted Outpatient Treatment
APC	Advanced Primary Care
ADHD	Attention-Deficit/Hyperactivity Disorder
BH	Behavioral Health
BPD	Borderline Personality Disorder
CACS	Consumer Assessment of Care Survey
CAHPS®	Consumer Assessment of Healthcare Providers and Systems
CBP	Controlling High Blood Pressure
CMH	Community Mental Health
CMHA	Community Mental Health Assessment
CMS	Centers for Medicare and Medicaid Services
CPT	Current Procedural Terminology
CPST	Community Psychiatric Support and Treatment
CSC	Coordinated Specialty Care
CVD	Cardiovascular Disease
DD	Difference in Difference Design
DOB	Date of Birth
DOH	New York State Department of Health
DSRIP	Delivery System Reform Incentive Payment
DUA	Data Use Agreement
ECHO	Experience of Care and Health Outcomes
ED	Emergency Department
EHR	Electronic Health Record
ER	Emergency Room
EQRO	External Quality Review Organization
FEP	First Episode Psychosis
FFS	Fee for Service
FTE	Full Time Equivalent
FUA	Follow-up After ED Visit for Alcohol and Other Drug Dependence
FUM	Follow-up After ED Visit for Mental Illness
GAF	Global Assessment of Functioning
GLMM	Generalized Linear Mixed Model
HARP	Health and Recovery Plans
HCBS	Home and Community Based Services
HEDIS®	Healthcare Effectiveness Data and Information Set
HHS	United States Department of Health and Human Services
HIV	Human Immunodeficiency Virus
IET	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
IMPACT	Improving Mood – Providing Access to Collaborative Treatment
IP	Inpatient
MAT	Medication-Assisted Treatment
MCO	Managed Care Organization
MHARS	Mental Health Acute Response Service
MHSIP	Mental Health Statistics Improvement Program
MIRECC	Mental Illness Research, Education, and Clinical Center
MMC	Medicaid Managed Care
NIMH	National Institute of Mental Health
NYC	New York City
NYS	New York State
NYSDOH	New York State Department of Health

NYSOH	New York State of Health
OASAS	New York State Office of Alcoholism and Substance Abuse Services
OMH	New York State Office of Mental Health
OTNY	OnTrackNY
PCMH	Patient Centered Medical Home
PCS	Perception of Care Survey
PMPM/Y	Per Member Per Month/Year
PPS	Performing Provider System
PROS	Personalized Recovery Oriented Services
PSM	Propensity Score Matching
PWI-A	Personal Wellbeing Index adult version
QARR	Quality Assurance Reporting Requirements
RAISE	Recovery After an Initial Schizophrenia Episode
RAISE-IES	Recovery After an Initial Schizophrenia Episode Implementation and Evaluation Study
RFP	Request for Proposals
ROS	Rest of the State
SDC	Self-Directed Care
SEES	Supported Education and Employment Specialist
SMI	Serious Mental Illness
SNP	Special Need Plan
SSI	Supplemental Security Income
SUD	Substance Use Disorder
UAS	Uniform Assessment System
VPN	Virtual Private Network

This Section describes the independent evaluation services that are required to be provided by the selected bidder. The selected bidder must be able to provide all of these services throughout the contract term.

PLEASE NOTE: Bidders will be requested to provide responses that address all of the requirements of this RFP as part of its Technical Proposal.

The terms “bidders”, “vendors” and “proposers” are also used interchangeably. For purposes of this RFP, the use of the terms “shall”, “must” and “will” are used interchangeably when describing the Contractor’s/Bidder’s duties.

The purpose of this RFP is to seek proposals from responsible and qualified contractors to conduct two (2) separate comprehensive, statewide interim independent evaluations (evaluation) in accordance with the Medicaid Redesign Section 1115 Demonstration, Special Terms and Conditions (STC).

1. The HARP evaluation will document the impact of both the Mainstream MMC carve-in of BH specialty services and the HARP implementation on health care service delivery, quality, health outcomes, and cost effectiveness of the HARP. In addition, program components that posed particular successes or challenges for implementation and outcomes for this population will also be examined. The evaluation will address the following goals: 1.) improvement in health and BH outcomes for adults in Mainstream MMC whose BH care was previously carved out in a FFS payment arrangement; 2.) improvement in health, BH, and social functioning outcomes for HARP enrollees; and 3.) improvement in recovery, social functioning, and community integration for individuals in the HARP meeting HCBS eligibility criteria.
2. The SDC Pilot evaluation will document the viability and effectiveness of the SDC Program in NYS for the HARP BH population and will address the following pilot program goals: 1.) implementation of a viable and effective SDC program for HARP-enrolled/BH HCBS-eligible individuals throughout NYS; 2.) improvement in recovery, health, BH, and social functioning for SDC participants; and 3.) maintenance of Medicaid cost neutrality overall and reduction of BH inpatient and emergency department service utilization and cost for SDC participants.

The evaluation plans must adhere to the evaluation standards set forth in Section XI (1 and 2) of the STC (https://www.health.ny.gov/health_care/managed_care/appextension/docs/2017-01-19_renewal_stc.pdf) and in 42 CFR 431.424. The Contractor may propose minor adjustments to the evaluation designs in Section 4.1, but with the understanding that CMS review/approval of the adjustments within the Expanded Evaluation Plan may affect the ability to complete the evaluations on time.

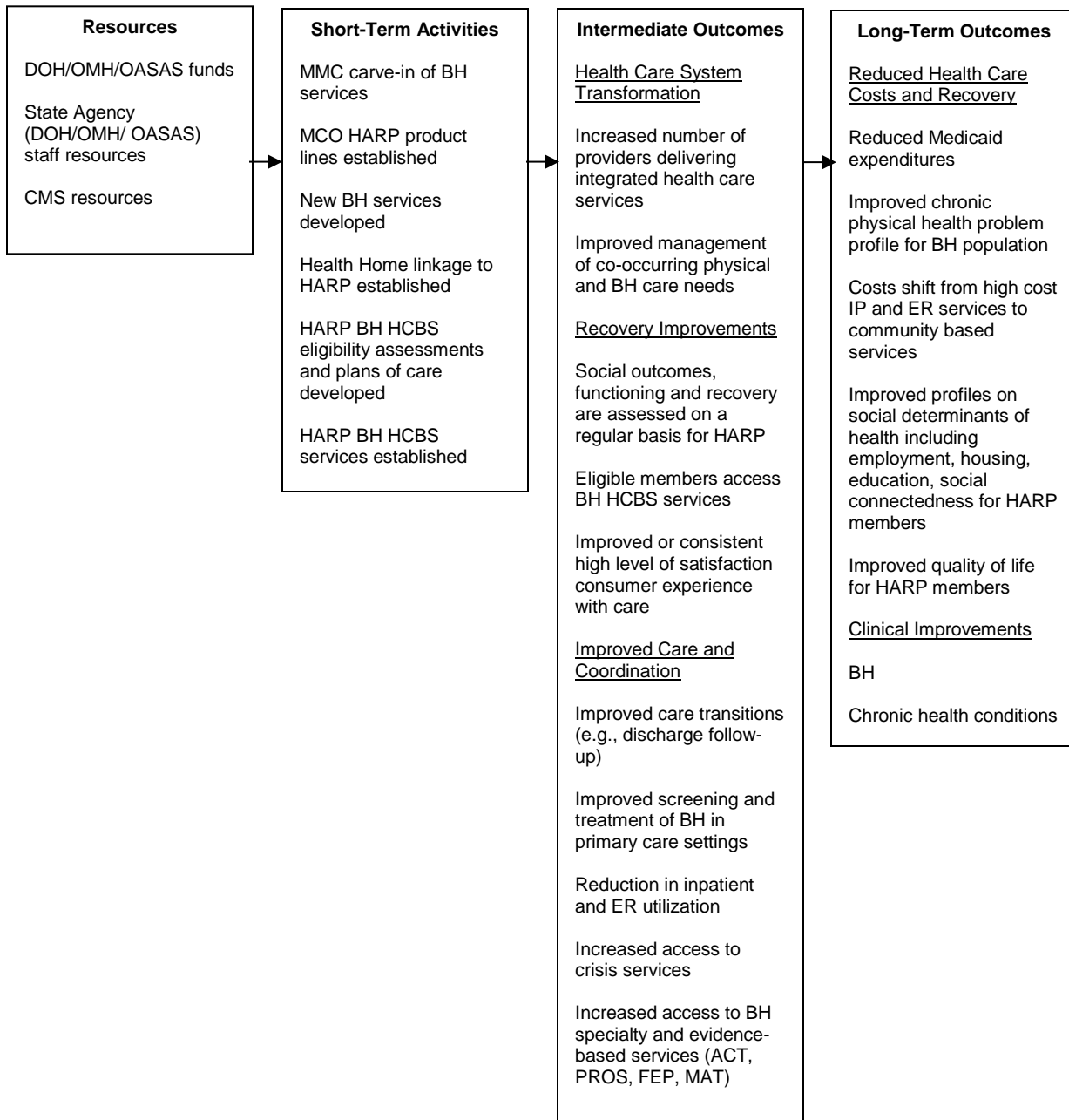
4.1 Tasks/Deliverables

Evaluation 1: HARP Program

This evaluation is a multi-method and robust statewide plan designed to examine the impact of the BH demonstration on health care service delivery, quality, health outcomes, and cost effectiveness of the HARP, as well as to determine program components that posed particular successes or challenges for implementation and outcomes. The figure below shows a logic model depicting the BH demonstration in NYS, which identifies the expected short-term activities, and intermediate and long-term program outcomes, and provides a guiding framework for the evaluation. Intermediate and long-term outcomes will be evaluated through this plan.

The evaluation will use quantitative methods to assess program outcomes statewide and by region (NYC and ROS) and will also track outcomes over time. Some outcomes will also be compared across plan type (e.g., MCO Mainstream, MCO HARP, MCO HIV SNP levels). Survey methods will be used to assess consumer experience with care and consumer perception of care. Qualitative methods such as patient focus groups will be used to provide context for the quantitative and survey findings, as well as to obtain insights on HARP program functioning and effectiveness from administrative, provider, and patient perspectives.

Logic Model of the Behavioral Health Demonstration in NYS

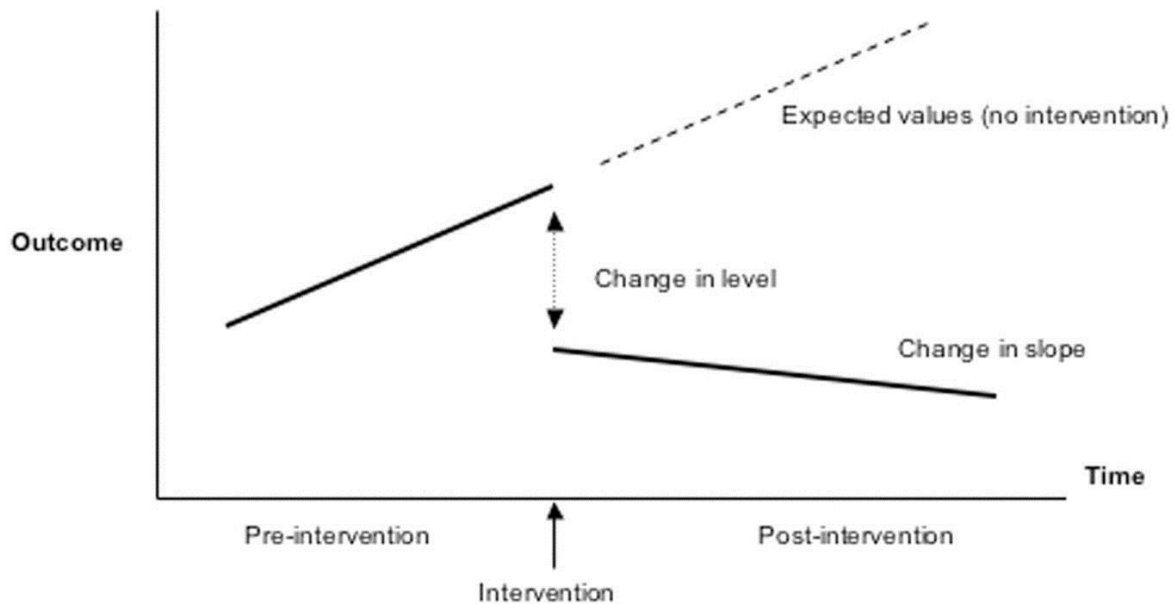


Quantitative Methods

A variety of quantitative analytic methods will be utilized by the Contractor to assess the BH demonstration in NYS Medicaid. Pre- and post-quasi-experimental design methods will include interrupted time series and difference in difference. Causal model designs will be applied in pre-design phases to develop comparable groups. Longitudinal mixed effect regression methods will be used to examine individual outcomes over time for the HARP population. Multiple analysis of variance and chi-square comparisons will be applied to compare population and acuity characteristics of the HARP qualified populations who are enrolled in HARPs, HIV SNPs, and Mainstream MMC plans by NYC and ROS on an annual basis. Survey methods and qualitative methods will be used to collect consumer input on the demonstration. Data available within the NYS Department of Health

(DOH) and Office of Mental Health (OMH) will be utilized for these analyses. Please note that depending on the goal and question addressed, “enrolled” may mean enrolled in a Mainstream MMC plan which includes BH carve-in, enrolled in a HARP plan, or enrolled in a HARP plan and eligible for BH HCBS. The following methodologies will be used in the evaluation.

1. Interrupted Times Series: This approach will involve a pre/post analysis of “enrolled” members using an interrupted time series design¹ to test hypotheses in assessing the BH demonstration and HARP’s statewide impact. This is a quasi-experimental design in which summary measures of the outcome variable are taken at equal time intervals over a period prior to program implementation (independent variable), followed by a series of measurements at the same intervals over a period following program implementation as demonstrated in the illustration below.



This design allows for the primary objective of evaluating trends/trajectory of outcome metrics such as cost before and after program implementation. The methods used in this design allow for a clear display of the monthly outcome variable trend over time, changes in outcome variable trajectory, as well as the dependencies or correlations between consecutive monthly measurements.

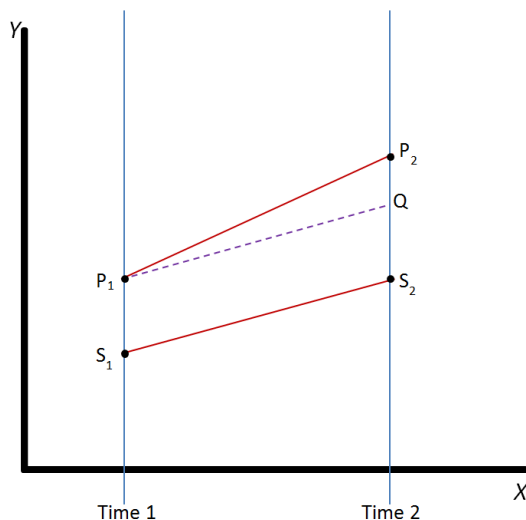
As with any program implementation analysis, the primary challenge is defining and acquiring groups between which to compare individuals within and without the implementation demonstration (i.e., non-BH or non-HARP as comparative groups for BH Mainstream and HARP enrolled individuals). This design was chosen in consideration of the fact that non-BH/non-HARP control groups are unlikely to be available, limiting the ability to separate the effects of the BH demonstration from other statewide health care reform initiatives that are ongoing. Given the limitation resulting from the likely absence of a comparison group, this design is advantageous in that potential confounders (i.e., other health care reform initiatives) are minimized in that they would have to occur contemporaneously with the introduction of the BH demonstration including HARPs to exert a confounding effect, which is unlikely, but is recognized as possible nonetheless. This design also has the advantage of accounting for secular trends in the outcome variables to which other non-BH demonstration health reform initiatives would be expected to contribute.

¹ Cook, TD, Campbell, DT. (1979). Quasi-experimentation: Design and analysis for field Settings. Boston, MA: Houghton Mifflin Company.

To utilize the strength of this design, a segmented regression² will be used to analyze the interrupted time series data. This analysis enables the evaluation of changes in the level and trend in the outcome variable from pre- to post-intervention, and uses the estimates to test causal hypotheses about the intervention. In the post-intervention period, actual rates for the various metrics for each month will be compared to expected rates, while controlling for characteristics of the patients enrolled in the program, secular trend, serial autocorrelation, and seasonal fluctuation in the outcome variable. Analysis will be limited to patients with continuous Medicaid enrollment for the 12 months prior to the given intervention. Variables included in the regression adjustment will include factors such as prior inpatient, emergency department (ED), and primary care utilization patterns (frequency), other resource use, and diagnostic history.

2. **Difference in Difference Design (DD):** A robust DD analysis will be performed using an appropriate control group (e.g., eligible individuals who opt out of the HARP (HARP-Opt Out) as controls for those who opt into HARP). To describe this further, persons eligible for HARP enrollment were identified using a Medicaid algorithm and passively enrolled in a HARP plan. However, they received a letter and could opt out of HARP enrollment resulting in two (2) groups: HARP enrolled and HARP eligible but not enrolled. This approach or strategy accounts for any secular trend/changes in the outcome metrics (it eliminates fixed differences not related to program implementation) with remaining significant differences attributable to the impact of program implementation.³ The study groups will be prepared by match-pairing individuals using propensity scores derived from logistic regression based on selected demographic, clinical, and social indicators, and health care utilization characteristics (see Quantitative Method 5, Propensity Score Matching). The outcome metrics, health care costs per member per month/year (PMPM/Y) and service use rates, such as hospital admit rates measured over two (2) consecutive periods of two (2) years before and two (2) years after program implementation will be calculated (total duration of four [4] years). Changes in outcome metrics from measurement period-1 (10/2013-9/2015), (7/2014-6/2016), to measurement period-2 (10/2015-9/2017), (7/2016-6/2018) will be compared for NYC and ROS, respectively. Also, changes in individuals who are HCBS eligible and opt for HCBS services will be compared to individuals who are HCBS eligible and do not opt for HCBS using similar match-pairing and DD techniques.

Idealized Representation of DD Method



² Wagner AK, Soumerai SB, Zhang F, Ross-Degnan D. Segmented regression analysis of interrupted time series studies in medication use research. *Journal of Clinical Pharmacy and Therapeutics* 2002; 27:299–309. [PubMed: 12174032]

³ Harman, JS, Lemak, CH, Al-Amin, M, Hall, AG, Duncan, RP. Changes in Per Member Per Month Expenditures after Implementation of Florida’s Medicaid Reform Demonstration. *Health Services Research*. 2010.01226.

3. Longitudinal Mixed Effect Regression Method: A Generalized Linear Mixed Model (GLMM) will be implemented to address the potential heterogeneity in the program/BH implementation effect and estimate an average program effect while controlling/adjusting for important covariates.^{4 5} The GLMM framework uses a model based approach to estimate HARP enrolled individual program effects allowing for program/BH implementation random effects.

This framework has the advantage of separating the effects of time from that of the BH implementation, accommodating the heterogeneity in the BH implementation effect, and accounting for serial correlations within individuals (resulting from repeated measurements). As with implementation longitudinal data, the outcome metrics such as employment, enrollment in formal education, social relationships, social strengths, and BH service utilization may vary considerably over time due to a strong temporal trend before and/or after program implementation. Risk factors including homelessness, criminal justice involvement (arrest history, incarceration history), alcohol use, drug use, chronic physical health conditions, and traumatic life events would likely vary considerably over time. The GLMM framework helps determine the amount of variability that may be due to temporal trend and the amount due to the new program implementation. The GLMM was chosen because it accounts for the intrinsic differences among individuals, the variability in program impact on individuals, and potentially induced correlation by collecting data on the same individuals over time.

4. Descriptive Statistics – Multiple Analysis of Variance and Chi-square Analysis: Comparisons will be made to examine characteristics of HARP enrollees in NYC and ROS in each annual period (October 2015 – 2019) using descriptive statistical methods for categorical, ordinal, or continuous data. Chi-square analysis comparing NYC to ROS as independent samples will be performed for categorical outcome variables. McNemar's chi-square test will be performed to compare binary outcomes between correlated groups for each region before and after implementation. Similar analysis will be conducted for comparing categorical outcome variables for each region year to year.

For continuous outcome variables, analysis of variance (ANOVA) will be used to test the difference in means score between independent samples from NYC and ROS. The use of repeated measures ANOVA for yearly changes within each region may be proposed by the Contractor, but an important assumption of the repeated measure ANOVA known as sphericity should be assessed for violations. Correlations between data in Year 1 and Year 2 may not be the same as Year 2 to Year 3 and likewise between Year 1 and Year 3. This condition of equal correlations from one year to the other can be a problem given the continuous assignment, and enrollment into HARPs as well as the complexities surrounding the BH implementation. Paired t-test will be used to compare pairs of years and, for multiple pair comparisons for measurement of three (3) years (comparing Year 3 with Year 2, and Year 3 with Year 1), a Bonferroni adjustment will be applied to the threshold p-value.

5. Propensity Score Matching: This method will involve using what is termed propensity or prognostic score matching to control for potential confounding by identifying a comparison group for specific study questions. This method will be used in combination with DD to examine the impact of the HARP benefit on health outcomes and to examine the impact of the HCBS on recovery outcomes. A comparison group for the HARP benefit will be members qualified for HARP plans who opted out of the HARP and are enrolled in Mainstream MMC. A comparison group to examine HCBS is HARP members eligible for HCBS but receiving only traditional (non-HCBS) services.⁶ This method will be applied in the design phase with application for all of the causal models. Using prior utilization and diagnostic information, this approach attempts to identify recipients with similar characteristics during and pre- and post-demonstration period. The method estimates each individual's conditional probability of being enrolled in HARPs (or HCBS for the assessment cohort). The propensity scores will be estimated using a logistic regression, with the outcome being opting to enroll into HARPs (coded 1 = HARPs, 0 = HARP-Opt Out), receiving HCBS (coded 1 = HCBS, 0 = No HCBS), and

⁴ Diggle, PJ, Heagerty, P, Liang, K-Y, Zeger, SL. Analysis of Longitudinal Data. New York: Oxford University Press, 2002.

⁵ Tooze, JA, Grunwald, GK, Jones, RH. Analysis of repeated measures data with clumping at zero. Statistical Methods in Medical Research. 2002, 11:341-355. [Pub Med: 12197301]

⁶ Austin, PC, Grootendorst, P, Anderson, GM. A comparison of the ability of different propensity score models to balance measured variables between treated and untreated subjects: a Monte Carlo study. Stat Med 2007; 26(4): 734-753. DOI: 10.1002/sim.2580.

predictors being derived from an array of demographic, clinical, and social indicator constructs. The potential confounders will be selected a priori based on subject matter knowledge and in consultation with subject matter experts.

A greedy matching algorithm with an appropriate matching ratio of HARPs to HARP-Opt Out (1:n) will be used to create a matched analytic cohort based on the estimated propensity score and other appropriate service use indicator such as the number of psychiatric hospitalization days prior to program implementation.⁷ Balance in covariate distribution between HARPs and HARP-Opt Out (or HCBS and No HCBS) in the matched analytic cohort will be assessed with weighted standardized difference.⁸ The matched cohorts will be used for the quantitative methods indicated above.

6. **Exponential Smoothing Methods:** An exponential smoothing method⁹ will be used to examine the monthly, quarterly, and yearly trends of service utilization or program enrollments, and cost of service use. In this method, the trend/trajectory of a series of summary measurements of the outcome variable (rate of service use and program enrollments) taken at equal time intervals over a defined period are analyzed using smoothing techniques. Service use or program enrollment projections based on exponential smoothing techniques are weighted averages of past service use or enrollments, with the weights decaying exponentially as the outcome/observations get older. Thus, the more recent the outcome, the larger the assigned weight. This allows for reliable examination of monthly, quarterly, and yearly trends, as well as future projections of program enrollment or service use. This method allows for a clear display of the monthly service use and cost trend over time, changes in service use, and cost trajectory as well as the intrinsic nature (i.e., the dependence or correlations between consecutive months) of one monthly outcome to the other.

Consumer Survey:

The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey is administered on a bi-annual basis with adults enrolled in all MMC product lines according to the current quality strategy approved by CMS in the 1115 Waiver. Adult members with BH needs are included in the CAHPS survey, but oversampling is not implemented to ensure there is representation of members with BH needs from mainstream product lines. The HARP MMC product lines were included in the CAHPS survey in 2018.

In addition, the HARP Perception of Care (HARP PCS) survey was developed by the State to evaluate HARP member perception of and experience with care. Members enrolled in HARPs and BH HCBS-eligible members enrolled in HIV SNPs are surveyed to measure experience with care, perception of care, and perception of quality of life. This PCS survey was derived from validated instruments intended to assess consumer perception of the performance of health plans and BH services. Specifically, questions were drawn from the Experience of Care and Health Outcomes (ECHO) Survey, the Mental Health Statistics Improvement Program (MHSIP)/OMH Consumer Assessment of Care Survey (CACs), the Personal Wellbeing Index adult version (PWI-A), and the Maryland Outcomes Measurement System. The OMH also formulated questions for pertinent topic areas where none could be found in existing instruments. The majority of questions address domains of member experience such as accessibility of services, quality of services, and appropriateness of care, wellness, quality of life, and social connectedness. Additionally, a set of socio-demographic questions are included which will allow examination of disparities. The survey consists of 63 questions and is found in Attachment D.

The HARP PCS was piloted by OMH in early 2017 and implemented in eight (8) OMH and NYS Office of Alcoholism and Substance Abuse Services (OASAS) programs. Additional survey questions were included to gather feedback from pilot participants about the length of the survey, clarity, and relevance of the questions. Surveys were implemented by New York State with the assistance of program administrators at selected programs and administered by non-direct care program staff at the pilot program sites. Participants completed the surveys on site, with the option of mailing the survey back to OMH individually or in a sealed individual envelope with other respondents. Completed surveys were processed and summarized by OMH. OMH also

⁷ Macro %gmatch. Available at: <http://bioinformaticstools.mayo.edu/research/wp-content/plugins/download.php?url=https://s3-us-west-2.amazonaws.com/mayo-bic-tools/sas/gmatch.sas>.

⁸ Austin, PC. Assessing balance in measured baseline covariates when using many-to-one matching on the propensity-score. *Pharmacoepidemiol Drug Saf* 2008; 17(12): 1218-1225. DOI: 10.1002/pds.1674

⁹ Brown, RG. (1962), *Smoothing, Forecasting and Prediction of Discrete Time Series*, New York: Prentice-Hall.

collected survey response rate and administration feedback from program sites. Final modifications to the HARP PCS were completed based on pilot findings in the third quarter of 2017. The first HARP PCS was implemented in the fourth quarter of 2017.

Qualitative Methods

Qualitative methods will include key informant interviews, focus groups, and surveys. Issues to be investigated qualitatively include notable program outcomes and challenges, effectiveness of governance structure and provider linkages, contractual and financial arrangements, changes in the delivery of patient care, the effect of other ongoing health care initiatives (e.g., Delivery System Reform Incentive Payment [DSRIP] Program, New York Prevention Agenda, Affordable Care Act) on the BH demonstration, HARP, and HCBS services implementation and operation, and patient experience and satisfaction with services. The Contractor will develop key informant and focus group interviews to address the questions under each objective. Development will include the determination of interview questions with review by DOH to ensure that questions are comprehensive, understandable, and reliable.

The Contractor will determine a strategy for identifying a range of stakeholders to target for in-depth interviews and focus groups. At a minimum, stakeholders are expected to include HARP enrollees, HARP Managed Care administrators, and HCBS service providers, and will reflect variation in region (NYC vs ROS) and other contextual factors (e.g., urban vs rural). Managed Care Plans, providers, and State groups will be semi-structured such that questions to be asked will address consistent topics for a given category of respondent (e.g., administrator, provider, enrollee), while at the same time allowing for follow-up questions to probe for more in-depth responses. Modifications in the interview questions will be made as necessary based on responses obtained in early interviews.

Analysis will follow a framework described by Bradley, Curry, and Devers¹⁰ that has been effectively used in health services research. Preliminary review of the data using a grounded theory approach (i.e., without predetermined categories) will be performed to identify emergent themes. A coding structure will then be established through an iterative process that labels concepts, relationships between concepts, and evaluative participant perspectives (i.e., statements that are positive, negative, or indifferent to their experiences or observations). The coding structure will also capture respondent characteristics (e.g., age, sex, position or role in organization) and setting (e.g., community based provider, HARP plan, MMC mainstream plan, NYS region). Responses will then be re-reviewed independently by at least (2) Contractor evaluation staff members, applying the finalized coding structure. Coding discrepancies between reviewers will be resolved through discussion to achieve consensus for the final coding of the data. Coded data will be analyzed and interpreted to identify major concept domains and themes.

Evaluation Design

Goal 1: Improve health and BH outcomes for adults in Mainstream MMC whose BH care was previously carved out in a FFS payment arrangement. (Mainstream MMC refers to Mainstream MMC enrollees in a Mainstream MMC plan which includes a BH carve-in.)

Question 1: To what extent are MMC enrollees accessing community-based behavioral specialty services (e.g., Assertive Community Treatment [ACT], Personalized Recovery Oriented Services [PROS], and first episode psychosis [FEP] programs)?

Hypotheses:

1. Utilization of BH specialty services will increase in the MMC population.
2. Identification of FEP will increase; utilization of evidence based care for FEP will increase; duration of untreated psychosis will decrease.

Question 2: To what extent are MMC enrollees accessing community-based health care or integrated health/BH care?

¹⁰ Bradley, AH, Curry, LA, Devers, KJ (2007). Qualitative data analysis for health services research: Developing taxonomy, themes, and theory. Health Services Research, 42(4), 1758-1772.

Hypotheses:

1. Percent of MMC BH members without primary care utilization will decline.

Methods:

Questions 1 and 2 will utilize a pre-post design with interrupted time series analysis (Quantitative Method 1). The proportion of MMC enrollees using any and specific BH specialty services and average units used pre and post (2011-9/2015: 10/2015 to 2019) will be examined. A similar design will be used to examine the proportion of MMC enrollees receiving integrated care in primary care settings and average units used pre and post (2011-9/2015: 10/2015 to 2019). In addition, the percent of MMC enrollees with BH needs with no claims history for primary and preventive services in each annual period pre and post (2011-9/2015: 10/2015 to 2019) will be examined. Data from Medicaid claims will be utilized to examine all service patterns.

It is expected that the use of BH specialty and integrated care services will be utilized by more individuals and that more units of service will be provided in the post intervention period compared to the pre- period. It is expected that the proportion of MMC enrollees with BH needs with no claims history for primary and preventive services in each annual period pre- compared to the post period will decline.

Complexity is recognized with respect to monitoring the utilization and update of treatment and services related to FEP and integrated primary care. Each topic is detailed below with respect to how evaluation questions related to services utilization will be approached by the Contractor.

FEP Services: The State provides evidence-based treatment for FEP using the OnTrackNY (OTNY) Coordinated Specialty Care (CSC) program. This program provides treatment to individuals between the ages of 16 and 30 who have experienced non-affective psychosis for less than two (2) years at the time of admission. CSC is a multi-disciplinary team approach for delivering evidence-based services to young people experiencing FEP with the goal of improving outcomes by providing early intervention services.¹¹ OTNY evolved from the Recovery After an Initial Schizophrenia Episode (RAISE) Connection program, which was developed in partnership with OMH as part of the National Institute of Mental Health (NIMH)-funded RAISE Implementation and Evaluation Study (RAISE-IES). OTNY is considered to be an evidence-based program model.^{12 13} The program currently has the capacity to serve 930 individuals per year across the State and 631 individuals are currently enrolled. Based on the incidence of schizophrenia (10 per 100,000), 2,000 new cases are expected per year. Based on the current sample of patients served in OTNY, an estimated 50% would be enrolled in Medicaid. It is notable that OTNY is a new program and has had limited enrollment prior to 2015. In addition, OTNY will be expanding across the State through the demonstration period.

It is notable that the current system for identification of FEP is driven primarily by provider referrals with Mainstream MMC plans assisting where possible. The State is working with Mainstream MMC plans to develop a referral and tracking methodology for these enrollees with priority given to OTNY program enrollment. In addition, FEP individuals can become eligible for HARP enrollment through the community referral process. Over the demonstration period, identification, tracking, and monitoring related to FEP is expected to become more robust.

The State also developed a Medicaid claims based algorithm which will be tested in collaboration with Mainstream MMC plans to develop capacity to identify incident cases of FEP using claims and potentially electronic health record (EHR) data. This methodology is emergent at this time and currently may be used for research purposes only. It is anticipated that this method will be used to capture a measure of duration of untreated psychosis to validate the accuracy of first episode occurrence and to understand if providers and plans are improving timely access to treatment.

¹¹ Heinssen, RK, Goldstein, AB, Azrin, ST. Evidence-Based Treatments for First Episode Psychosis: Components of Coordinated Specialty Care. Rockville, MD, National Institute of Mental Health, 2014. Available at www.nimh.nih.gov/health/topics/schizophrenia/raise/nimh-white-paper-csc-for-fep_147096.pdf

¹² Dixon, LB, Goldman, HH, Bennett, ME, et al. Implementing coordinated specialty care for early psychosis; the RAISE Connection Program. *Psychiatric Services* 66:691-698, 2015

¹³ Kane, JM, Robinson, DG, Schooler, NR, et al. Comprehensive versus usual community care for first-episode psychosis: 2-year outcomes from the NIMH RAISE Early Treatment Program. *American Journal of Psychiatry*

It is anticipated that over the course of the demonstration that the identification of incident cases of FEP will become more robust. Using this algorithm, the State plans to identify Medicaid recipients meeting potential FEP criteria to examine the rate of identification of FEP in the MMC population over the 2015-2019 period and the duration of untreated psychosis. The Contractor will use the methods and technologies developed, including individuals identified by DOH using this algorithm.

The OTNY data system provides a unique opportunity for the Contractor to identify the Mainstream MMC or HARP enrollees who are receiving OTNY services. Outcomes including rates of engagement, hospitalization, and school and work participation are monitored via the OTNY data system. Outcomes related to Medicaid service utilization for emergency, inpatient, outpatient, and HCBS services will also be monitored. The FEP utilization will be captured from the OTNY data system. The proportion of MMC enrollees receiving an evidence-based treatment for FEP will be tracked using the OTNY data system.

Identification of FEP and utilization of the FEP programs is expected to increase over the course of the demonstration. The FEP is not currently a billable Medicaid service in NYS, although NYS MMC plans are required to offer FEP as a plan benefit. It is anticipated that, at some point in the future, the FEP program will become a billable Medicaid service and utilization will be monitored using Medicaid claims.

Integrated BH Care: Provision of integrated BH care programs is an integral part of the DSRIP Medicaid system redesign. Currently, the State has three (3) options for BH Integration under DSRIP¹⁴ (Project 3ai). In the NYS implementation of DSRIP, every Performing Provider System (PPS) chose model 1 and some combination of the other two (2) models outlined below, but there is not a minimum number of program sites operating selected models. As a result, the level of penetration of the model within the PPS is not readily determined.

1. Model 1: Bringing BH services into a Patient Centered Medical Home (PCMH) or advanced primary care (APC) practice. The PPS work in partnership with BH providers to offer BH services on site. Providers implement a preventative screening (Patient Health Questionnaire [PHQ]-9, Screening, Brief Intervention, and Referral to Treatment [SBIRT]) to identify unmet BH needs. If/when screenings are positive, the provider refers the patient to a BH provider for further evaluation and/or treatment.
2. Model 2: Bringing a primary care provider to a BH clinic. PPS identify BH service sites interested in providing/integrating primary care services on location. The provider then works with a BH provider to identify community needs, develop a structure for integration requirements, and develop evidence-based standards of care.
3. Model 3: Implementing the IMPACT model (Collaborative Care) in a primary care practice. The Improving Mood – Providing Access to Collaborative Treatment (IMPACT) Model employs a collaborative team of professionals with complementary skills to fully integrate BH treatment into primary care. This team includes a depression care manager, a primary care provider, and a consulting psychiatrist. The patient's primary care provider works with the care manager to develop and implement a stepped care treatment plan, and consults with the psychiatrist to change the course of treatment for patients who do not improve after 10 to 12 weeks. In over 80 randomized controlled studies, IMPACT has shown to improve PHQ-9 scores by more than 50% in 12 months.

The DSRIP metrics for integrated care are process metrics related to implementation of the elements of the chosen model. These process metrics rely on Medicaid claims and encounters and other reporting requirements specific to the New York State independent assessment and oversight of DSRIP. Population level outcomes would also be expected from having these services available to the Medicaid population. The DSRIP outcomes such as reduction of ER utilization and hospital readmissions on a PPS level would be expected to improve over the course of the demonstration. At this time, the State has implemented rate codes for Integrated Outpatient Services, which will allow identification of a subset of integrated BH care using Medicaid claims data. The State will make available aggregate findings from PPS to use as benchmarks, if necessary.

¹⁴ New York State Department of Health. New York State Delivery System Reform Incentive Payment Program Project Toolkit. http://health.ny.gov/health_care/medicaid/redesign/docs/dsrp_project_toolkit.pdf

Q#	Outcome	Measure	Data Source	Hypotheses	Methods
1	Improve access to BH care specialty services	Proportion of enrollees using any and specific BH specialty services and average units used pre and post (2011-9/2015: 10/2015 to 2019)	Medicaid claims OnTrackNY client records	Utilization of BH specialty services will increase in the MMC population	Pre-post design with interrupted time series analysis
1	Improve identification of and access to care for FEP patients	Percent of MMC population identified as having first episode psychosis in each annual period from baseline (2015 to 2019); proportion of MMC population utilizing evidence based care for FEP in each annual period (2015 to 2019).	Medicaid claims OnTrackNY client records	Identification of FEP will increase; utilization of evidence based care for FEP will increase; duration of untreated psychosis will decrease	Pre-post design with interrupted time series analysis
2	Improve access to primary and preventive services	Percent of MMC BH population enrolled for entire prior 12 months with no claims history for primary and preventive services in each annual period pre-post (2011-9/2015: 10/2015 to 2019)	Medicaid claims	Percent of MMC BH members without primary care utilization will decline	Pre-post design with interrupted time series analysis

Goal 2: Improve health, BH, and social functioning outcomes for adults in the HARP. (HARP refers to HARP enrollees in HARP or HIV SNP plans)

Question 1: How has enrollment in HARP plans increased over the length of the demonstration?

Hypotheses:

1. The HARP enrollment will increase and the majority of HARP eligibles will enroll in HARP or HIV SNP plans rather than MMC mainstream plans.

Methods:

The HARP plan enrollment will be assessed within the context of overall program enrollment. To assess the impact of HARP roll-out, the evaluation will examine how many HARP-eligible members are enrolled in each annual period in each MMC, HARP, or HIV SNP. It is important to note that, for this measure, there is no pre-implementation comparison or other group comparison available. Quantitative Method 4 will be used to monitor year to year comparisons in NYC and ROS in each annual period for the period 10/2015 to 9/2019. It is expected that enrollment in HARP plans will increase over the length of the demonstration as new members are identified and original members opt to remain in the HARP or HIV SNP plans rather than joining a MMC mainstream plan. It is expected that the majority of HARP eligibles will enroll in HARP or HIV SNP plans rather than in Mainstream MMC plans. Medicaid enrollment data will be used for this analysis. Medicaid enrollment data are available lagged by one (1) month. The first nine (9) months of the implementation includes only NYC plans with the ROS beginning July 2016.

Question 2: What factors are associated with individuals choosing to opt out of HARP plans?

Hypotheses:

1. The HARP eligible members who opt out are younger and less behaviorally acute than those who remain enrolled in HARP/HIV SNP.

Methods:

The demographic (age, gender, race, residential region), diagnostic (Dx) (MH Dx, SUD Dx, Dual Dx) and acute BH service utilization (BH inpatient [IP], SUD IP detox, SUD IP rehabilitation) characteristics of HARP-eligible members who are enrolled in each annual period in MMC, HARP, or HIV SNPs will be compared (Quantitative Method 4). Demographic characteristics will be categorical, diagnostic characteristics dichotomous (y/n), and BH service utilization will be characterized as number of episodes in a year or number of days utilized for each service type per year. Comparisons will be made using chi-square analysis and ANOVA, as appropriate, according to data type (Quantitative Method 4).

It is hypothesized that HARP-eligible members who opt out may be younger and less behaviorally acute than those who remain enrolled in HARP/HIV SNP. Medicaid enrollment and claims data will be used for this analysis. Medicaid enrollment data are lagged by one (1) month. Medicaid claims data are lagged by six (6) months. It should be noted that the first nine (9) months of the implementation includes only NYC plans with ROS beginning in July 2016.

In addition, the qualitative reasons members have for opting back into Mainstream MMC is being collected by the State to assess reasons for opting out of the HARP. The data collected include a categorical list of reasons for declining and allow for open ended response by enrollees. The data are summarized on a weekly basis for NYC and ROS. The reasons for opting out will be monitored over time and cumulated by year from October 2015 to September 2019. It is important to note that these data are not available on an individual member basis. Data are collected by the enrollment broker in the NY Medicaid Choice Enrollment data system; however, no recipient identifier is retained with the data.

Question 3: What are the demographic, social, functional, and clinical characteristics of the HARP population? Are they changing over time?

Hypotheses:

1. On a population level, it is expected that the distribution of the measured risk factors and protective factors for this population will shift toward fewer risk factors and greater protective factors over time as the program matures; regional (NYC vs ROS) differences in improvements will be observed. On an individual level, trajectories of improvement in risk and protective factors over time will be observed.

Question 4: What are the educational and employment characteristics of the HARP population? Are they changing over time?

Hypotheses:

1. Higher rates of educational and employment attainment will be observed for the HARP enrolled population over time as the program matures; individual level improvements will be noted.

Methods:

Questions 3 and 4 examine the detailed socio-demographic data which will be available for HARP enrollees in HARP and HIV-SNP plans via the BH HCBS Eligibility Brief Assessment and BH HCBS Full Assessment. These assessments are derived from the interRAI™ Community Mental Health Assessment®¹⁵. The BH HCBS Eligibility Brief Assessment is required annually for all HARP enrollees and HARP-eligible HIV SNP enrollees. As such, this detailed information will be available for HARP/HIV SNP members, but is not available for HARP eligible members who opt out and return to MMC mainstream plans. Prior to March 2017, for screened individuals who met BH HCBS eligibility criteria, a BH HCBS Full Assessment was completed and repeated annually. The BH HCBS Full Assessment was not required after March 2017.

¹⁵ Hirdes JP, Marhaba M, Smith TF, Clyburn L, Mitchell L, Lemick RA, Telegdi NC, Pérez E, Prendergast P, Rabinowitz T, Yamauchi K, Resident Assessment Instrument-Mental Health Group: Development of the resident assessment instrument--mental health (RAI-MH). Hosp Q. 2000, 4: 44-51.

Two (2) analytic approaches will be applied to these data to examine the above questions: population level year by year comparisons (Quantitative Method 4) and individual level analysis of change over time (Quantitative Method 3). First, population characteristics will be examined in each annual period (October 2015 to 2019) for HARP enrollees in HARP and HIV-SNP plans in NYC and ROS. Characteristics examined include socio-demographic, clinical, and recovery related measures including education, employment, social network, risk factors, home environment, social relationships, criminal justice involvement, top health diagnoses, behavioral diagnoses, BH symptoms, substance related practices and BH services accessed (see Attachment E for the BH HCBS Eligibility Brief Assessment Tool and Attachment F for the BH HCBS Full Assessment Tool). These indicators will be coded as categorical, ordinal, or continuous variables as appropriate for analysis. Comparisons using Quantitative Method 4 include descriptive statistical methods (e.g., ANOVA, Chi-square) for categorical, ordinal, or continuous data. It is expected that the distribution of the measured risk factors and protective factors for this population will shift toward fewer risk factors and greater protective factors. Regional (NYC vs ROS) differences in improvements may be observed. Specifically, higher rates of educational and employment attainment will be observed among HARP enrollees over time as the program matures. Paired t-test will be used to compare pairs of years and for multiple pair comparisons, for measurement of three (3) years (comparing Year 3 with Year 2 and Year 3 with Year 1) a Bonferroni adjustment will be applied to the threshold p-value.

Individual level change will be examined using longitudinal data analytic methods (Quantitative Method 3). Individuals will have repeated BH HCBS Eligibility Brief Assessments and BH HCBS Full Assessments completed. Longitudinal change in risk and protective factors identified above will be examined to determine change trajectories using multivariable mixed effects regression methods (Quantitative Method 3). Fixed effects will be identified including age, gender, and race/ethnicity and time. Random effects will include risk and protective factor level at each annual time point.

It is important to note that, for these questions, there is no pre-implementation comparison group available. The risk and protective, employment and education data collected via the BH HCBS Eligibility Brief Assessment and BH HCBS Full Assessment as part of this demonstration are not available prior to the demonstration so no pre-post comparison can be made. For some analyses, assessment data may be matched to enrollment and services data in the DOH Medicaid Data Warehouse. Each assessment includes Medicaid Id so matching between the assessment data and Medicaid data will not be a barrier. In addition, since the HARP demonstration applies to ages 21-64, it is not anticipated that the age structure of the eligible population will change. However, this will be examined to determine if changes in the population age structure may be impacting the analysis.

Question 5: To what extent are HARP enrollees accessing primary care?

Hypotheses:

1. Percent of HARP members without primary care access will decline.

Methods:

Pre-post approaches (Quantitative Method 2) will be used to assess access to primary care among two (2) groups: 1.) individuals who were HARP-eligible pre-implementation but never enrolled in a HARP (HARP eligible only); and 2.) individuals who enrolled in HARP or HIV SNP plans post-implementation (HARP enrolled). The unit of analysis will be rate of primary or preventive care visits measured as members receiving one (1) or more primary or preventive care visits in a year (e.g., the use of evaluation and management Current Procedural Terminology (CPT) codes or well visit codes by primary care physicians) from Medicaid claims data. It is anticipated that HARP enrollees will access primary and preventive care at greater rates in comparison to HARP-eligible populations prior to the demonstration. Changes in use of primary care and preventive care from measurement period 1 (10/2013 – 9/2015), (7/2014-6/2016) to measurement period-2 (10/2015 – 9/2017), (7/2016 – 6/2018) will be compared for NYC and ROS, respectively. Comparable members during the pre- and post-periods will be selected using the HARP population algorithm and propensity score matching techniques (Quantitative Method 5). Medicaid claims will be utilized for these analyses.

Question 6: To what extent are HARP enrollees accessing community-based behavioral specialty services?

Hypotheses:

1. Access to and utilization of BH specialty services will increase.

Methods:

Pre-post approaches (Quantitative Methods 1 and 2) will be used to assess access to community-based behavioral specialty services (ACT, PROS, OMH Outpatient Clinic, Continuing Day Treatment, Partial Hospitalization, OASAS Opioid Treatment Program, OASAS Outpatient Clinic, and treatment for first episode psychosis) among HARP-eligible only compared to HARP enrolled. The unit of analysis will be rates at which members use community-based BH specialty services in a month/quarter and within the year. This will be measured as the proportion of members receiving one or more community based BH specialty service in each service category in a month/quarter and within the year. It is anticipated that HARP enrollees will access community-based BH specialty services at greater rates in comparison to HARP-eligible populations prior to the demonstration. Changes in use of BH specialty services from measurement period 1 (10/2013 – 9/2015), (7/2014-6/2016) to measurement period-2 (10/2015 – 9/2017), (7/2016 – 6/2018) will be compared for NYC and ROS, respectively. Analysis evaluating the monthly/quarterly utilization trends of community-based BH specialty services using Quantitative Method 1 may be limited to only HARP enrollees receiving HCBS. Comparable members during the pre and post periods will be selected using the HARP population algorithm and propensity score matching techniques (Quantitative Method 5). Analysis evaluating the changes in yearly utilization of community-based BH specialty services in the comparable matched cohort will be conducted using Quantitative Method 2. Medicaid claims will be utilized for these analyses.

Question 7: To what extent are HARP enrollees accessing Health Homes for care coordination?

Hypotheses:

1. Access to care coordination services will increase in terms of Health Home engagement for HARP members.

Methods:

Pre-post approaches (Quantitative Method 1 and 2) will be used to assess access to Health Home care coordination among HARP-eligible only compared to HARP enrolled. The measure to be used will be the proportion of HARP enrollees engaged in Health Homes pre and post measurement period 1 (10/2013 – 9/2015), (7/2014-6/2016) to measurement period-2 (10/2015 – 9/2017), (7/2016 – 6/2018) for NYC and ROS, respectively. It is expected that access to care coordination services will increase in terms of Health Home engagement for HARP members.

Analysis evaluating the monthly/quarterly enrollments in Health Homes (utilization over time) will be conducted using Quantitative Method 1. Analysis evaluating the changes in yearly utilization of Health Homes in the comparable matched cohort will be conducted using Quantitative Method 2. Comparable members during the pre and post periods will be selected using the HARP population algorithm and propensity score matching techniques (Quantitative Method 5). Medicaid claims and encounters will be utilized for these analyses.

Question 8: To what extent is HARP quality of care improving, especially related to the Healthcare Effectiveness Data and Information Set (HEDIS®) /Quality Assurance Reporting Requirements (QARR) measures of health monitoring, prevention, and management of chronic health conditions?

Hypotheses:

1. The HEDIS® / QARR quality profiles for HARP plans will improve over time as the program matures.

Methods:

Pre-post approaches (Quantitative Method 2) will be used to assess improvements in quality of care related to health monitoring, prevention, chronic health, and BH among HARP eligible only compared to HARP enrolled. The measure specifications follow HEDIS® specifications for each measurement year.¹⁶ Note that it is expected HEDIS® quality of care metrics and value sets to change over the course of the demonstration period. The Contractor will be expected to apply definitions as deemed appropriate. It is expected that care quality will improve in the areas of BH, cardiovascular disease, asthma, and diabetes (see table below). Changes in these measures from measurement period 1 (10/2013 – 9/2015), (7/2014-6/2016) to measurement period-2 (10/2015 – 9/2017), (7/2016 – 6/2018) will be compared for NYC and ROS, respectively. Comparable members during the

¹⁶ National Committee for Quality Assurance. HEDIS® 2016 Technical Specifications for Health Plans, Volume 2; October 2015.

pre and post periods will be selected using the HARP population algorithm and propensity score matching techniques (Quantitative Method 5). Metrics for these analyses are plan reported as part of the Medicaid quality oversight. These analyses may supplement plan submitted data with Medicaid claims data to enhance rates or may recalculate administratively derived HEDIS® metrics using Medicaid claims so that appropriate pre and post periods can be selected and to allow for identification of appropriate comparison groups.

Outcome	HEDIS® Measure Name	Source
BH	Antidepressant Medication Management	Claims
BH	Diabetes Monitoring for People with Diabetes and Schizophrenia	Claims
BH	Diabetes Screening for People with Schizophrenia/Borderline Personality Disorder (BPD) Using Antipsychotic Medication	Claims
BH	Cardiovascular Monitoring for People with Cardiovascular Disease (CVD) and Schizophrenia	Claims
BH	Follow-up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medications	Claims
BH	Follow-up after Hospitalization for Mental Illness	Claims
BH	Adherence to Antipsychotic Medications for People with Schizophrenia	Claims
BH	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)	Claims
BH	Follow-up After ED Visit for Mental Illness (FUM)	Claims
BH	Follow-up After ED Visit for Alcohol and Other Drug Dependence (FUA)	Claims
Diabetes	Comprehensive Diabetes Care	Claims
Cardiovascular	Controlling High Blood Pressure (CBP)	Plan submitted
Asthma	Medication Management for People with Asthma	Claims

Question 9: To what extent are HARP enrollee experiences with care and access to health and BH services positive?

Question 10: To what extent are HARP enrollees satisfied with the cultural sensitivity of BH providers and their wellness, recovery, and degree of social connectedness?

Hypotheses:

1. Perception of experience of care and satisfaction with care will improve over time as the program matures.
2. The HARP enrollee satisfaction with the cultural sensitivity of their BH providers will increase over the length of the demonstration.
3. The HARP enrollee satisfaction with their wellness, recovery, and degree of social connectedness will improve over the time of the demonstration.

Methods:

Question 9 will utilize the Health Plan version of the CAHPS survey to examine HARP enrollee experience with care and perception of access to health and BH services. It is expected that HARP enrollee experience with care and perceived access to health and BH services will improve over time. Quantitative Method 4 will be used to examine year to year comparisons of the survey responses by NYC and ROS.

The CAHPS survey was administered to adults via a contract with an External Quality Review Organization (EQRO) in 2017 and will be administered again in 2019. The survey administration will include a random sample of individuals in HARPs. The survey is administered by both mail and telephone, and assesses patients' experiences with health care providers and health plan staff. This includes information on patient experience with access to care, experiences with health care providers, and health plan support. Questions specific to BH include: need for mental health or SUD treatment, access to mental health or SUD treatment, satisfaction with mental health or SUD treatment, and self-rating of overall mental health.

Given confidentiality agreements, only de-identified CAHPS data will be available for use. This limits the ability to make pre-post comparisons. In addition, the survey will not be oversampled in terms of mainstream populations with mental health issues or HARP-eligible enrollees in HIV SNP plans. This limitation also applies to current CAHPS results. Since the BH population is not oversampled, it is not possible to examine what the existing reporting patterns are for this sub-population.

Question 10 will utilize the HARP PCS (see Attachment D). It is expected that HARP enrollee satisfaction with the cultural sensitivity of their BH providers will increase over the length of the demonstration. It is also expected that HARP enrollee satisfaction with their wellness, recovery, and degree of social connectedness will improve over the time of the demonstration. Quantitative Method 4 will be used to examine year to year comparisons of the survey responses by NYC and ROS.

The PCS was developed by NYS with advocate, program, and psychiatric research input. The PCS is derived from a number of standardized instruments including: the Experience of Care and Health Outcomes (ECHO) Survey, the Mental Health Statistics Improvement Program (MHSIP) Survey, the Personal Wellbeing Index adult version (PWI-A), and the Maryland Outcomes Measurement System. The OMH also formulated questions for pertinent topic areas where none could be found in existing instruments. The PCS is designed to collect experience with BH care in terms of access and perception of quality of life in the areas of health, wellness, and social functioning. The PCS is collected on a random sample of HARP members in HARP and HIV-SNP plans in 2017 and 2019. The annual implementation will be via a contract with an EQRO.

Since this is a new survey, the State piloted the instrument and obtained consumer feedback in early 2017. The 2017 pilot was conducted by OMH and OASAS program staff and occurred in BH specialty program settings including ACT, PROS, and OASAS outpatient rehabilitation programs. Medicaid-eligible consumers in these settings were expected to be HARP enrolled. Agency consumer affairs liaisons assisted program staff with the survey implementation and obtaining consumer feedback. Changes were made to the survey based on the pilot findings.

The HARP members enrolled in HARP or HIV-SNP plans are surveyed starting in 2017. The survey is implemented by the EQRO using a random sampling methodology of HARP enrollees by product line for HARPs and HIV SNPs. Methods to improve the response rate from this representative sample will include reminder calls and mailings.

Measures will be derived at the domain and item levels. Specific survey domains include Perception of Outcomes, Access and Quality of Care, Appropriateness of Services, Social Connectedness, Wellness, and Quality of Life. Demographics are also collected on the form to monitor disparities. Items that will be measured include member's perception of BH provider's responsiveness to their cultural background, a seven (7) item scale measuring satisfaction with quality of life, presence of social support, relationships, and beliefs about health and wellness. In terms of specific measurement methods, satisfaction with quality of life is measured on a scale from 0 to 10, social connectedness items will be measured on a five (5) item Likert agreement scale, and beliefs about health and wellness will be measured on a four (4) item Likert frequency scale. The full survey can be found in Attachment D. Data from this survey will allow the State and plans to monitor HARP members' perception of services and how their BH services affect different areas of their life. Findings will be examined for change in BH services satisfaction levels over time. Surveys will be identified to allow for linking responses to Medicaid claims and other administrative data.

It is expected that survey responses will be consistently high and improving over the demonstration time frame. Pre and post comparisons will not be possible given that the HARP PCS will be implemented in the 2017-2019 periods with no pre-demonstration data collection.

Question 11: To what extent are HARPs cost effective? What are the PMPM cost of inpatient psychiatric services, SUD ancillary withdrawal, hospital-based detox, and ER services for the HARP population? Are these costs decreasing over time?

Hypotheses:

1. It is expected that costs for HARP enrollees are shifting from acute services to non-acute outpatient based health and BH services.

Methods:

Pre-post approaches (Quantitative Methods 1 and 2) will be applied to these data to examine the trends and potential changes in costs for care for HARP-eligible members following the implementation of the program. This global assessment will examine whether shifting costs in any of the named service types above are offset elsewhere in the continuum of care. It is expected that costs for HARP enrollees are shifting from acute services to non-acute outpatient based health and BH services. To assess the potential/expected shifts in cost over time, two (2) separate trend analyses using Quantitative Method 1 will be conducted to 1) evaluate the PMPM cost trend of acute BH services, and 2) evaluate the PMPM costs trend of non-acute outpatient services for HARP enrollees pre and post program implementation. In addition, changes in mean annual PMPM cost acute BH services and non-acute outpatient services in the comparable matched cohort will be conducted using Quantitative Method 2.

The analyses, PMPM cost of acute and non-acute services as described above, will be conducted using data from measurement period 1 (10/2013 – 9/2015), (7/2014-6/2016) to measurement period-2 (10/2015 – 9/2017), (7/2016 – 6/2018) for NYC and ROS, respectively. Comparable members during the pre and post periods will be selected using the HARP population algorithm and propensity score matching techniques (Quantitative Method 5). Medicaid claims will be utilized for these analyses.

Q#	Outcome	Measure	Data Source	Hypotheses	Methods
1	Increase HARP enrollment	HARP eligible members who in each annual period are in MMC, HARP or HIV SNP (10/2015 -2019)	Medicaid enrollment	HARP enrollment will increase and the majority of HARP eligibles will enroll in HARP or HIV SNP plans rather than MMC mainstream plans	Year to year comparisons in NYC and ROS in each annual period for the period 10/2015 to 9/2019 and reported at the end of the demonstration period (Quantitative Method 4)
2	Describe characteristics of members electing to or declining enrollment in HARP and reasons for declining enrollment in HARP	Group differences in demographic (age, race, gender), BH service utilization, and diagnostic characteristics of the HARP eligible enrolled members in HARP/HIV-SNP and HARP eligible who opt out for Mainstream MMC in each annual period (10/2015-2019). The qualitative reasons for opting out of HARP will be monitored over time and	Medicaid claims Medicaid Choice enrollment data	HARP eligible members who opt out are younger and less behaviorally acute than those who remain enrolled in HARP/HIV SNP	Demographic characteristics, BH service utilization, diagnosis on a year to year basis during the demonstration period. Comparisons will be made using chi-square analysis and ANOVA as appropriate

Q#	Outcome	Measure	Data Source	Hypotheses	Methods
		cumulated by year 10/2015 to 9/2019.			according to data type (Quantitative Method 4).
3	Compare demographic, social, functional and clinical characteristics of the HARP enrolled population and demographics characteristics of the HARP enrolled compared to HARP eligible population	<p>Year to year comparison (baseline 10/2015-9/2019) of HARP enrollees in terms of social, functional and clinical characteristics in each annual period (10/2015-9/2019) language, risk factors, home environment, social relationships, criminal justice involvement, top health diagnoses, behavioral diagnoses, BH symptoms, substance related practices and BH services accessed.</p> <p>Measures that will be tracked in each annual period are:</p> <p>Percent of HARP enrollees by the following socio-demographic characteristics: age, sex, gender identity, race, ethnicity, preferred language, marital status, education, and sexual orientation</p> <p>Percent of HARP enrollees with the following risk factors: homelessness, criminal justice involvement (arrest history, incarceration history), alcohol use, drug use, chronic physical health conditions, and traumatic life events</p> <p>Percent of HARP enrollees with the following protective factors: employment, enrollment in formal education, social relationships, social strengths, and BH service utilization</p>	<p>Medicaid claims</p> <p>BH HCBS Eligibility Brief Assessment</p> <p>BH HCBS Full Assessment</p>	On a population level, it is expected that the distribution of the measured risk factors and protective factors for this population will shift toward fewer risk factors and greater protective factors over time as the program matures; regional (NYC vs ROS) differences in improvements will be observed. On an individual level, trajectories of improvement in risk and protective factors over time will be observed.	Two (2) analytic approaches will be applied to these data to examine the above questions: population level year by year comparisons (Quantitative Method 4) and individual level analysis of change over time using Quantitative Method 3 (GLMM) will be implemented to address the potential heterogeneity in the program/BH implementation effect and estimate an average program effect while controlling/adjusting for important covariates
4	Improve educational and employment characteristics of the HARP population	<p>Year to year comparison (baseline 10/2015-9/2019) of average HARP beneficiary scores on employment status, employment arrangement, employment compensation, employment supports, enrollment in formal education, and education supports.</p> <p>Measures that will be tracked</p>	<p>Medicaid claims</p> <p>BH HCBS Eligibility Brief Assessment</p>	Higher rates of educational and employment attainment will be observed for the HARP enrolled population over time as	Two (2) analytic approaches will be applied to these data to examine the above questions: population level year by year comparisons (Quantitative

Q#	Outcome	Measure	Data Source	Hypotheses	Methods
		<p>are:</p> <p><u>Employment</u></p> <ol style="list-style-type: none"> 1. The percentage of members currently employed 2. The percentage of members currently competitively employed 3. The percentage of members employed at least 35 hours per week in the past month 4. The percentage of members employed at or above the minimum wage 5. The percentage of members who prefer change in their employment situation 6. The percentage of members who prefer change in employment supports <p><u>Education</u></p> <ol style="list-style-type: none"> 7. The percentage of members currently enrolled in a formal education program 8. The percentage of members who prefer change in their level of education 9. The percentage of members who prefer a change in educational support services 	BH HCBS Full Assessment	the program matures; individual level improvements will be noted	Method 4) and individual level analysis of change over time using Quantitative Method 3 (GLMM) will be implemented to address the potential heterogeneity in the program/BH implementation effect and estimate an average program effect while controlling/adjusting for important covariates
5	Improve access to primary and preventive services	Percent of HARP-eligible members in pre period compared with HARP enrolled members in post period with no claims history for primary and preventive services pre and post measurement period-1 (10/2013 – 9/2015), (7/2014-6/2016) to measurement period-2 (10/2015 – 9/2017), (7/2016 – 6/2018)	Medicaid claims	Percent of HARP members without primary care access will decline	Quantitative Method 2 pre-post design with DD analysis; Quantitative Method 2; Quantitative Method 5.
6	Improve access to BH care specialty services	Proportion of HARP enrollees using any and specific BH specialty services pre and post measurement period-1 (10/2013 – 9/2015), (7/2014-6/2016) to measurement period-2 (10/2015 – 9/2017), (7/2016 – 6/2018)	Medicaid claims	Access to and utilization of BH specialty services will increase	Quantitative Method 1 pre-post design with interrupted time series analysis; Quantitative Method 2; Quantitative Method 5.
7	Increase access to care coordination (Health Homes)	Proportion of HARP enrollees engaged in Health Homes pre and post measurement period-1 (10/2013 – 9/2015), (7/2014-6/2016) to measurement period-2 (10/2015 – 9/2017), (7/2016 – 6/2018)	Medicaid claims	Access to care coordination services will increase in terms of Health Home engagement	Quantitative Method 1 pre-post design with interrupted time series analysis; Quantitative Method 2;

Q#	Outcome	Measure	Data Source	Hypotheses	Methods
				for HARP members	Quantitative Method 5.
8	Improve quality of care related to health monitoring, prevention, chronic health and BH	HEDIS®/QARR rates for HARP plans measurement period-1 (10/2013 – 9/2015), (7/2014-6/2016) to measurement period-2 (10/2015 – 9/2017), (7/2016 – 6/2018)	HEDIS®/QARR Medicaid claims	HEDIS®/QARR quality profiles for HARP plans will improve over time as the program matures	Comparable members during the pre and post periods will be selected using the HARP population algorithm and propensity score matching techniques (Quantitative Method 5); Quantitative Method 2 pre-post design with using DD analysis
9 & 10	Improve HARP enrollees self-reported experience of care related to access, health, BH and HCBS; Improve HARP enrollees' satisfaction with care in terms of wellness and recovery, social connectedness and cultural sensitivity of services.	Percent of HARP enrollees that were satisfied with access to care, communication and knowledge of Medicaid managed care in each annual period (2017-2019) Measures derived from the CAHPS survey that will be tracked in 2017 and 2019 are: Percentage of HARP enrollees who report it was easy to get mental health treatment Percentage of HARP enrollees who report it was easy to get SUD treatment Percentage of HARP enrollees who rated their mental health treatment positively Percentage of HARP enrollees who rated their SUD treatment positively Percentage of HARP enrollees who rated items related to communication with health care providers positively Measures that will be derived from the PCS are:	CAHPS Survey HARP Perception of Care Survey (PCS)	Perception of experience of care and satisfaction with care will improve over time as the program matures. HARP enrollee satisfaction with the cultural sensitivity of their BH providers will increase over the length of the demonstration. HARP enrollee satisfaction with their wellness, recovery, and degree of social connectedness will improve over the time of the demonstration.	Quantitative Method 4 comparisons in NYC and ROS in each annual period that data are available for the period 10/2015 to 9/2019

Q#	Outcome	Measure	Data Source	Hypotheses	Methods
		<p>Percentage of HARP members who report that BH care was responsive to their cultural background in each annual period (2017-2019)</p> <p>Percent of HARP members who had a positive overall rating of quality of life in each annual period (2017-2019).</p> <p>Percent of HARP members who had overall positive beliefs about health and wellness in each annual period (2017-2019)</p> <p>Percent of HARP members who rated PCS questions in the social connectedness domain positively in each annual period (2017-2019).</p>			
11	Decrease PMPM cost of inpatient psychiatric services, SUD ancillary withdrawal, hospital-based detox and ER services for the HARP population	PMPM cost of acute and non-acute services will be conducted using data from measurement period-1 (10/2013 – 9/2015), (7/2014-6/2016) to measurement period-2 (10/2015 – 9/2017), (7/2016 – 6/2018)for NYC and ROS respectively.	Medicaid claims	It is expected that costs for HARP enrollees are shifting from acute services to non-acute outpatient based health and BH services.	Quantitative Method 1 pre-post design with interrupted time series analysis; Quantitative Method 2

Goal 3: Develop HCBS focused on recovery, social functioning, and community integration for individuals in HARPs meeting eligibility criteria. (HARP refers to HARP enrollees in HARP or HIV SNP plans.)

Question 1: Access to Care: To what extent are HARP enrollees deemed eligible to receive HCBS?

Hypotheses:

1. It is expected that 75% of HARP members will be eligible for any HCBS, 75% of HARP members will be eligible for HCBS Tier 1, and 70% of HARP members will be eligible for HCBS Tier 2 by the end of 2019.

Methods:

Question 1 focuses on examining the HCBS eligibility determinations for HARP members and HARP eligible HIV SNP members. All HARP and HARP eligible HIV SNP members will be assessed for HCBS eligibility using the BH HCBS Eligibility Brief Assessment. The BH HCBS Eligibility Brief Assessment is used to identify individuals who may have functional needs and service/support needs that could be addressed by HCBS. The HCBS are divided into two (2) tiers. Eligibility for Tier 1 services will include a lower threshold for needs than Tier 2 services. Tier I includes peer, employment and/or education supports. Tier 2 includes all Tier 1 BH HCBS plus additional services as specified in the table below to individuals whose medical need surpasses the need for Tier 1 services. Crisis respite HCBS are available to all HARP enrollees, regardless of the tier under which they receive services. This includes intensive crisis respite or short-term crisis respite in a dedicated facility. Prior to March 2017, individuals determined to be HCBS eligible received a comprehensive assessment using the BH HCBS Full

Assessment tool. The BH HCBS Full Assessment was used to develop a client-centered plan of care for the individual. The BH HCBS were offered beginning in January 2016 in NYC and in October 2016 for ROS.

It is expected that 75% of HARP members will be eligible for any HCBS, 75% of HARP members will be eligible for HCBS Tier 1 services, and 70% of HARP members will be eligible for HCBS Tier 2 services. It is expected that these targets will be achieved by the end of the demonstration. Comparisons will be made to examine characteristics of HARP enrollees deemed eligible in NYC and ROS in each annual period (October 2015-2019), and from year to year using descriptive statistical methods for categorical, ordinal or continuous data (Quantitative Method 4). Data from the BH HCBS Eligibility Brief Assessment (demographic, clinical) and from Medicaid claims (plan membership, HCBS eligibility status) will be utilized for these analyses.

It is important to note that, for this measure, there is no pre-implementation comparison possible. For Goal 3, Questions 1 and 2, it is expected that as the HARP program matures, those members eligible for HCBS and those receiving HCBS can be compared to those deemed ineligible or eligible but not accessing services. These comparisons should examine any significant differences in terms of population demographic characteristics (e.g., age, gender, residential region), plan membership (HARP Plan) and clinical characteristics (e.g., Mental Health Dx, SUD Dx, Dual Dx).

BH HCBS:

<p>BH HCBS Assessment</p> <ul style="list-style-type: none"> ● BH HCBS Eligibility Brief Assessment ● BH HCBS Full Assessment
<p>Rehabilitation</p> <ul style="list-style-type: none"> ● Psychosocial Rehabilitation ● Community Psychiatric Support and Treatment (CPST)
<p>Empowerment Services-Peer Supports</p>
<p>Habilitation Services</p>
<p>Respite</p> <ul style="list-style-type: none"> ● Short-term Crisis Respite ● Intensive Crisis Respite
<p>Non-medical transportation</p>
<p>Family Support and Training</p>
<p>Employment Supports</p> <ul style="list-style-type: none"> ● Pre-vocational ● Transitional Employment ● Intensive Supported Employment ● On-going Supported Employment
<p>Education Support Services</p>

Question 2: To what extent are HARP enrollees who are deemed HCBS-eligible receiving HCBS?

Hypotheses:

1. It is expected that PMPM BH HCBS utilization will increase over the course of the demonstration.

Methods:

The expectation is that the monthly and annual utilization of HCBS will increase over the demonstration period. It is expected that 75% of HARP members deemed eligible for HCBS will utilize these services. The monthly and annual rate of utilization of BH HCBS will be examined using Quantitative Method 6. The unit of analysis will be rates at which HARP enrollees deemed eligible use BH HCBS in a month and within the year. This will be measured as the proportion of HARP enrollees receiving one or more BH HCBS in each tier in a month and within the year. Rates will be examined monthly and annually at the statewide, regional and HARP plan levels over the period 2016-2019. Also, average annual percent change in program enrollments or service use or both will be assessed at the statewide, regional levels from year to year starting from 2016 and thereafter. The average annual percent change for the year of assessment will be calculated as the difference in average service use between that year and the prior year divided by the average of the prior year. Data from the BH HCBS Eligibility Brief Assessment (demographic, clinical) and from Medicaid claims (plan membership, HCBS eligibility status) will be utilized for these analyses. Additionally, GLMM (Quantitative Method 3) will be used to examine the association between BH HCBS utilization for those deemed eligible (used versus not, used six [6] or more months versus less) controlling for demographic and clinical characteristics, and time.

It is important to note that, for this measure, there is no pre-implementation comparison possible. For Question 1 and Question 2, it is expected that as the HARP program matures, those members eligible for HCBS and those receiving HCBS can be compared to those deemed ineligible or eligible but not accessing services. These comparisons should examine any significant differences in term of population demographic characteristics (e.g., age, gender, residential region), plan membership (HARP Plan) and clinical characteristics (e.g., Mental Health Dx, SUD Dx, Dual Dx).

Question 3: To what extent has the demonstration developed provider network capacity to provide BH HCBS for HARPs?

Hypotheses:

1. It is expected that the number and ratio of BH HCBS providers per 1,000 enrollees will increase over the course of the demonstration.

Methods:

This question addresses the need for HARP /HIV SNP network adequacy to provide HCBS. It is important to note that, for this measure, there is no pre-implementation comparison possible, but as the HARP program matures, it will be possible to monitor rates of provider participation in HARPs/HIV SNPs and the rate of providers per member population.

The extent to which HCBS providers are available and contracted with by MMC HARP/HIV SNP plans will be examined. The measures include the number of providers contracted for BH HCBS in MMC HARP plans and the ratio of BH HCBS providers per 1,000 BH HCBS eligible enrollees. Year to year comparisons for the period 2016-2019 at the statewide, NYC, and ROS, county and HARP plan levels will be conducted (Quantitative Method 4). The MMC HCBS Provider Network Data System will be used to determine HCBS provider information related to geographic areas served and plan contracts. Medicaid claims will be used to determine HARP enrollment.

A year to year comparison of the number of complaints related to access to HCBS will be done. Collection of complaints related to HCBS is done through a designated email address which has been available to BH HCBS providers since October 2015. Designated staff monitor and manage the mailbox. Designated staff has created an extended tracking system that includes multiple fields. These fields include origin of inquiry, type of inquiry, Primary and Secondary topics, fields for each MCO to indicate if they are part of the inquiry, which NYS region the inquirer is located in, name of the inquirer, and if forwarded to other state agencies. Through this data collection, issues related to HCBS are identified, monitored and remedied.

Monitoring of complaints is coordinated between OMH, OASAS and DOH. The DOH, OMH, and OASAS meet regularly to identify trends, urgent issues and outstanding emails. The OMH is able to generate complaint reports from a linked database. These reports can be created via subject matter, if routed to DOH/OASAS, type of inquiry (complaint, question) and date opened/completed.

Question 4: Does targeting of BH HCBS more narrowly lead to increased numbers of members without access to appropriate BH care? (What are the consequences of targeting availability of BH HCBS to a more narrowly defined population than the criteria in the State Plan?)

Hypotheses:

1. It is expected that the added costs arising from access to BH HCBS will be offset elsewhere in the continuum of care.

Methods:

The Contractor will examine how total costs PMPM have increased or decreased following the implementation of HARP and for HARP enrollees with and without BH HCBS access through HARPs using Quantitative Methods 1 and 2. The Contractor will develop a pre-post design that examines the potential changes in costs for care for HARP-eligible members following the implementation of the program.

It is expected that the added costs arising from access to BH HCBS are offset elsewhere in the continuum of care. For example, it is expected that costs and utilization of employment, education or peer services will offset hospital costs and utilization over the course of the demonstration.

The outcome metrics, health care costs per member per month/year (PMPM/Y) and service use rates, such as hospital admit rates measured over two (2) consecutive periods of two (2) years before and two (2) years after program implementation will be calculated (total duration of four [4] years). Changes in outcome metrics from measurement period 1 (10/2013 – 9/2015), (7/2014-6/2016) to measurement period-2 (10/2015 – 9/2017), (7/2016 – 6/2018), will be compared for NYC and ROS, respectively. Also, changes in individuals who are HCBS eligible and opt for HCBS will be compared to individuals who are HCBS eligible and do not opt for HCBS using similar match-pairing and DD techniques. Specific HCBS types will also be tested. Changes in individuals who are Tier 1 HCBS eligible and opt for Tier 1 HCBS will be compared to individuals who are Tier 1 HCBS eligible and do not opt for Tier 1 HCBS using similar match-pairing and DD techniques. Additionally, changes in individuals who are Tier 2 HCBS eligible and opt for Tier 2 HCBS will be compared to individuals who are Tier 2 HCBS eligible and do not opt for HCBS using similar match-pairing and DD techniques.

Q#	Outcome	Measure	Data Source	Hypotheses	Methods
1	Access to Care: Over the demonstration period, increase the number of HARP enrollees assessed for eligibility to receive HCBS.	Year to year comparison of statewide, NYC, and ROS rates of percentages of HARP enrollees deemed eligible for any and for specific HCBS	BH HCBS Eligibility Brief Assessment BH HCBS Full Assessment Medicaid claims	It is expected that 75% of HARP members will be eligible for any HCBS, 75% of HARP members will be eligible for HCBS Tier 1 and 70% of HARP members will be eligible for HCBS Tier 2 by the end of 2019	Comparisons will be made to examine characteristics of HARP enrollees deemed eligible in NYC and ROS in each annual period (10/2015-2019), and from year to year using descriptive statistical methods for categorical, ordinal or continuous data (Quantitative Method 4).
2	Access to Care: Over the course of the demonstration, increase the number of HARP enrollees	The monthly and annual rate of utilization of BH HCBS will be examined at the statewide, regional	Medicaid claims BH HCBS Eligibility Brief Assessment	It is expected that PMPM BH HCBS utilization will increase over the course of	Monthly and yearly rate of utilization of BH HCBS will be examined using Quantitative Method 6 and

Q#	Outcome	Measure	Data Source	Hypotheses	Methods
	who are deemed HCBS eligible receiving HCBS.	and HARP plan levels over the period 2016-2019. Data from the BH HCBS Eligibility Brief Assessment (demographic, clinical) and from Medicaid claims (plan membership, HCBS eligibility status) will be utilized for these analyses to examine relationships between the demographic and clinical characteristics and service utilization.		the demonstration.	GLMM, Quantitative Method 3 used to address the potential heterogeneity in BH HCBS use and estimate an average program effect while controlling/adjusting for important covariates Rates will be examined at the statewide, regional and HARP plan levels over the period 2016-2019
3	Provider network capacity to provide BH HCBS for HARPs is developed.	Year to year comparison of statewide, NYC, and ROS rates of BH HCBS provider participation in MMC plans by county; ratio of BH HCBS providers per 1,000 enrollees; examine complaints and appeals to determine if plans, providers or members have requested BH HCBS but were denied receipt of those services	BH HCBS Eligibility Brief Assessment BH HCBS Full Assessment Medicaid claims Complaints and appeals submitted to the State MMC HCBS Provider Network Data System	It is expected that the number and ratio of BH HCBS providers per 1,000 enrollees will increase over the course of the demonstration	Year to year comparisons for the period 2016-2019 at the statewide, NYC, and ROS, county and HARP plan levels will be conducted (Quantitative Method 4).
4	Access to care: The consequences of targeting availability of BH HCBS to a more narrowly defined population than the criteria in the State Plan are described. PMPM costs of BH HCBS for HARP enrollees who receive services are offset elsewhere in the continuum of care.	Outcome metrics, health care costs per member per month/year (PMPM/Y) and service use rates, will be calculated (total duration of four [4] years). Changes in outcome metrics from measurement period- 1 (10/2013 – 9/2015), (7/2014-6/2016) to measurement period- 2 (10/2015 – 9/2017), (7/2016 – 6/2018), will be compared for	Medicaid claims BH HCBS Eligibility Brief Assessment BH HCBS Full Assessment	It is expected that the added costs arising from access to BH HCBS will be offset elsewhere in the continuum of care.	Quantitative Methods 1 and 2: A pre-post design that examines the potential changes in costs for care for HARP-eligible members following the implementation of the program. The outcome metrics, health care costs per member per month/year (PMPM/Y) and service use rates, such as hospital

Q#	Outcome	Measure	Data Source	Hypotheses	Methods
		NYC and ROS, respectively. Also, changes in individuals who are HCBS eligible and opt for HCBS will be compared to individuals who are HCBS eligible and do not opt for HCBS using similar match-pairing and DD techniques.			admit rates measured over two (2) consecutive periods of two (2) years before and two (2) years after program implementation will be calculated (total duration of four [4] years). Changes in outcome metrics from measurement period-1 (10/2013 – 9/2015), (7/2014-6/2016) to measurement period-2 (10/2015 – 9/2017), (7/2016 – 6/2018), will be compared for NYC and ROS, respectively. Also, changes in individuals who are HCBS eligible and opt for HCBS will be compared to individuals who are HCBS eligible and do not opt for HCBS using similar match-pairing and DD techniques.

Evaluation 2: Self-Directed Care (SDC) Pilot Program

The evaluation of the SDC Pilot program consists of two (2) components: 1.) a process evaluation of the implementation of the SDC pilot with the purpose of determining the viability of BH SDC in NYS and assessing factors that will facilitate or challenge statewide roll-out for HARP enrollees; and 2.) an outcome evaluation to examine the impact of SDC on participant health, BH, and quality of life as well as any impact on Medicaid spending.

Process Evaluation

The Process Evaluation will be used to address the research questions relating to implementation of the program (Goal 1, Questions 1-4). The Contractor will use qualitative methodologies to examine the perspectives of a variety of pilot participants including SDC participants, Support Brokers, pilot site agency leadership, Advisory Council members, and fiscal intermediary and OMH program staff. The purpose of this evaluation is to assess the context and process of implementation of the pilot program and identify facilitators and barriers that could impact eventual implementation of a program for BH SDC throughout NYS.

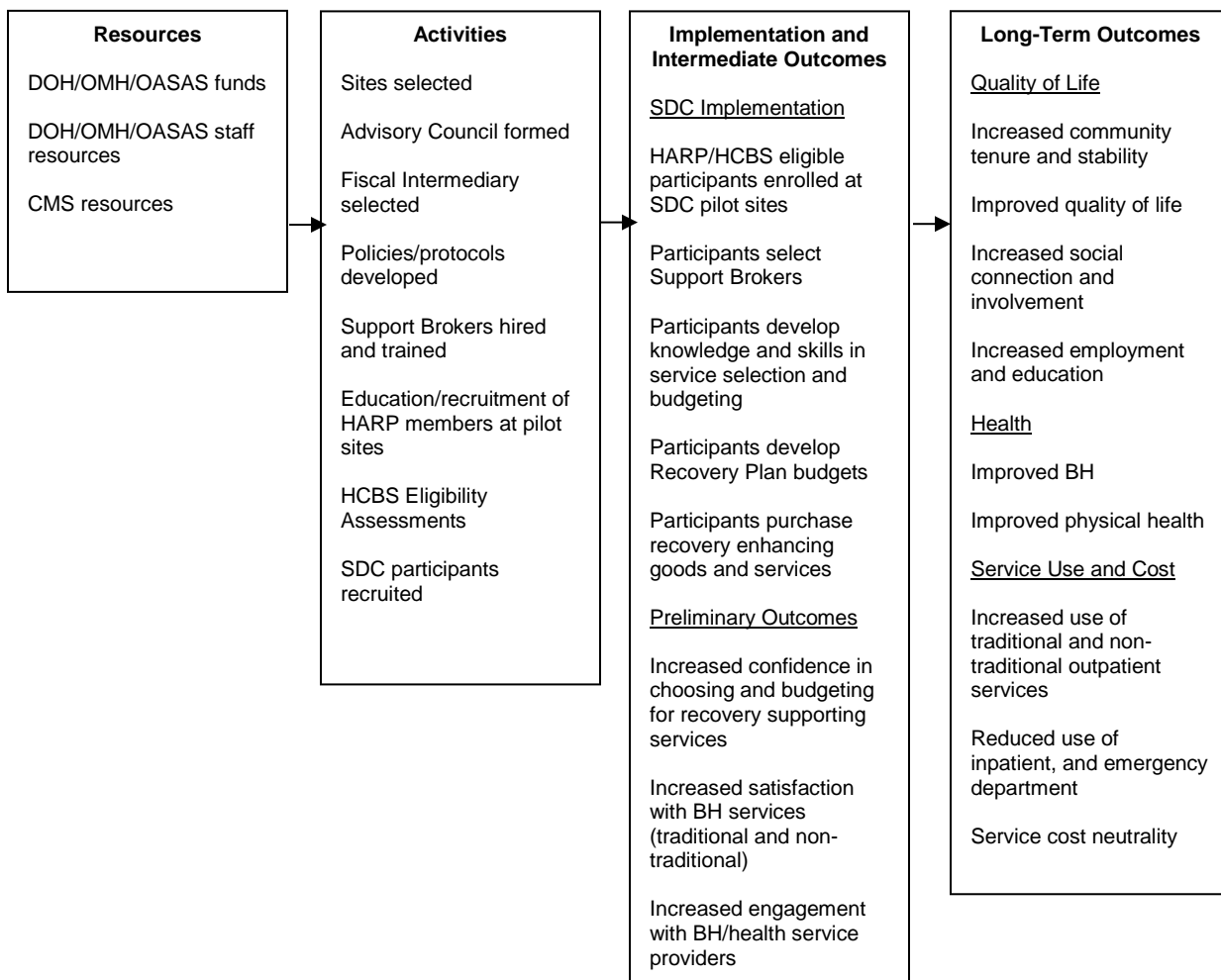
Outcome Evaluation

The Outcome Evaluation will be used to address the research questions relating to improvement in SDC participant recovery, quality of life, health and BH, and satisfaction with care (Goal 2, Questions 1-6). In addition, the Outcome Evaluation will address the research questions on Medicaid service utilization and cost (Goal 3, Questions 1-3). The design of the outcome evaluation will be quasi-experimental. Eligibility criteria for SDC participants includes Medicaid enrollment, HARP enrollment, and eligibility for HCBS. A comparison group will

consist of Medicaid and HARP-enrolled and HCBS-eligible individuals served in locations where SDC pilot programs are not available. Propensity score matching will be used to identify a comparison group comprised of Medicaid/HARP/HCBS-eligible individuals who live in areas similar to the locations of the SDC sites and who are similar to the SDC participant group on important covariates. The comparison group will also allow the Contractor to assess SDC program effects separately from the effects of other Medicaid Redesign initiatives implemented concurrently in NYS.

The figure below shows a logic model of the SDC Pilot demonstration showing expected resources, preliminary activities, implementation and intermediate outcomes, and long-term outcomes. The logic model provides a framework for both components of the evaluation. Data for the process evaluation of the implementation will come primarily from documents, site visits, interviews, and focus groups. Data to inform the outcome evaluation will come from several sources. The BH HCBS Eligibility Assessment is conducted annually for all HARP enrolled/HCBS eligible individuals including SDC participants. This instrument is based on the InterRAI™ Community Mental Health Assessment, and gathers information about demographics, treatment history, housing, judicial system involvement, employment, education, risk behaviors, functional status, adverse life events, and social relationships. The HARP PCS (Attachment D) is also gathered annually from SDC participants and contains questions about quality of life and perception of care. The data from these two (2) sources will be used to measure outcomes under Goal 2. Medicaid claims and encounter data will be used to measure changes in patterns of health and BH service utilization and cost that address the questions under Goal 3.

SDC Pilot Logic Model:



Methods:

For the process evaluation of SDC program implementation, the primary method will be qualitative analyses of data from interviews, focus groups, and documentation. For the outcome evaluation, three (3) analytic approaches will be used. To gain a preliminary understanding of the characteristics of SDC participants, comparison group members and the larger HARP and HCBS-eligible population, and to assess any differences in sub-groups (e.g., women, urban residents) descriptive statistics with corresponding graphical illustrations will be used. Assessment of outcomes over time for SDC participants (and in some domains for the comparison group) will be conducted using GLMM. The GLMM enables multivariate modeling on different types of outcome variables including rates (e.g., outpatient service use), non-normal distributions (e.g., cost), and categorical or indicator variables (e.g., arrested in past year) as well as normally distributed continuous outcomes. Random effects will be incorporated in the models on two (2) levels: for persons within areas/site and for change over time within persons. Incorporating random effects allows for the accurate modeling of heterogeneity and correlation within both the SDC population and comparison group. The DD analyses will also be conducted to compare change over time between the two (2) groups. A DD analysis assesses whether the relationship between trends over time for two (2) groups prior to a cut-off point changes after the cut-off point; the assumption is that without the intervention, the relationship between the trends for the two (2) groups would remain the same. In this case, the intervention is the SDC Pilot program, cut-off point is enrollment in the SDC Pilot program, and patterns over time will be assessed for variables including rates of BH inpatient use and overall Medicaid spending.

Comparison Group (Propensity Score Matched [PSM] Group)

Propensity Score Matching (PSM) will be used to derive the comparison group using the following approach. Comparison group members are required to be HARP-enrolled and HCBS-eligible, which by definition means that they have been administered the BH HCBS Eligibility Assessment and will be re-assessed annually. The pool of individuals who have been assessed using the Community Mental Health (CMH) screen statewide is currently over 20,000. Areas with similar features to the areas of the SDC site populations should be selected (e.g., other areas within NYC or other large urban areas like Buffalo or Rochester will be selected for matching to the NYC SDC location, and areas of small cities will be selected for matching to the Newburgh SDC location). The number of areas selected should be adequate to obtain a sufficient pool for the next step. In the next step, Propensity Score Matching will be used to identify a comparison group matched to SDC participants using the CMH screen data and Medicaid claims data. As described below, the strategy will result in a larger (1:n) but analytically matched comparison group with covariate distributions balanced between the SDC group and the PSM comparison group.

An important aspect of the use of a comparison group is to control for the effects of other Medicaid Redesign initiatives implemented concurrently with SDC. The areas of the SDC sites and the other areas chosen for the comparison group will be assessed for the presence of other initiatives and these will be factored into the balancing of the SDC and comparison groups on an area level. The comparison group will be used to partially address most of the research questions under Goals 2 and 3 using either GLMM or DD described below. The exceptions are Research Questions 1 and 6 under Goal 2, as these rely solely on indicators contained in the HARP PCS. As the HARP PCS for non-SDC participants is based on annual random sampling, it will not be used as a basis for the PSM comparison group but will be used to descriptively compare the larger HARP-enrolled population to SDC participants.

Quantitative Methods

1. **Descriptive Statistics:** Descriptive statistics including frequencies, measures of central tendency (means, medians), and distributions (histograms, boxplots) will be used to describe the characteristics of SDC participants, comparison group members, and HARP and HCBS-eligible individuals more generally. To describe univariate differences or similarities between the SDC and comparison groups or between sub-populations of interest (e.g., based on site, gender, diagnosis), chi-square tests, t-tests, or ANOVAs will be conducted depending on variable type. To describe simple differences between time periods (pre to post SDC), paired sample t-tests will be used. Bonferroni adjustments for multiple tests will be applied to the threshold p-value as necessary. Non-parametric tests will be used for measures that do not follow distributional assumptions.

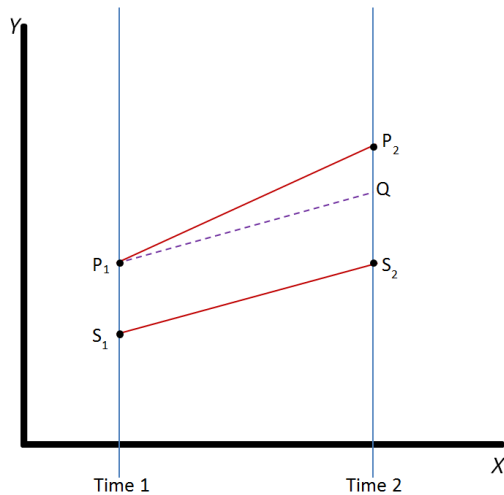
2. Longitudinal Mixed Effect Regression: The primary analytic approach used to assess change in the SDC participant group will be GLMM. The GLMM can address the potential heterogeneity in the SDC pilot implementation effect and estimate an average program effect while controlling for important covariates^{17,18}. This framework has the advantage of separating the effects of time from that of the SDC implementation, accommodating the heterogeneity in the SDC implementation effect, and accounting for serial correlations within individuals (resulting from repeated measurements). Random effects will be included on one (1) or two (2) levels depending on the model and use of the comparison group. For all of the models, change over time should be allowed to vary across individuals. This has the advantage that different numbers and times of measurements across individuals can be used; it also accurately accounts for correlation between measurements within individuals. These models will be used for HARP PCS data as well as CMH screen data for the SDC participant group. Random effects will also be used on the area/site level described in the “Comparison Group” section above. Individuals should be allowed to vary within areas to more accurately assess area level effects and to be able to identify SDC program effects apart from effects that may result from differences in areas (e.g., large urban versus small city; additional service initiatives). These models will be used with the PSM Comparison Group, but limited to CMH screen or Medicaid claims data. As with implementation longitudinal data, the outcome metrics such as employment, enrollment in formal education, social relationships, social strengths, and BH service utilization may vary considerably over time due to a strong temporal trend before and/or after program implementation. Explanatory risk factors including homelessness, criminal justice involvement (arrest history, incarceration history), alcohol use, drug use, chronic physical health conditions, and traumatic life events would likely vary considerably over time. The GLMM framework helps determine the amount of variability that may be due to temporal trend and the amount due to the new program implementation. The GLMM was chosen because it accounts for the intrinsic differences among individuals, the variability in program impact on individuals, and the correlation potentially induced by collecting data on the same individuals over time. The GLMM will also usefully incorporate the PSM comparison group to look at differences over time in outcomes between SDC and the comparison group with the ability to more accurately model differences in persons by area. This would enable detection of program effects by separately comparing the two (2) program site areas with similar areas in NYS.
3. DD Analysis: The primary method used to assess differences in service use, cost, and outcomes between the SDC participant group and the quasi-experimental comparison group will be a DD analysis. This approach or strategy accounts for any secular trend/changes in the outcome metrics (it eliminates fixed differences not related to program implementation), with remaining significant differences attributable to the impact of program implementation¹⁹. The study groups will be prepared by match-pairing individuals using propensity scores derived from logistic regression based on selected demographic, clinical, and social indicators, and health care utilization characteristics (see Quantitative Method 4). The outcome metrics, health care costs per member per month (PMPM) and service use rates, such as hospital admission rates, will be measured over two (2) consecutive periods. Periods of 18 months prior and 18 months following program enrollment will be assessed to examine changes in trends. Changes in outcome metrics from the prior measurement period to the post measurement period will be compared. Although the approximate measurement periods for 18 months are pre-period (July 1, 2016 – December 31, 2017) and post-period (January 1, 2018 – June 30, 2019), the actual trends will be based on SDC participant enrollment. For example, for a participant whose enrollment was on June 1, 2018, their last pre-period month would be May 2018 and their first post-period month would be June 2018. For later enrollees, the pre and post-periods may need to be reduced. The matches in the PSM comparison group will be assigned the same pre and post periods. Averages over years will be calculated from the PMPM rates.

17 Diggle, P.J.; Heagerty, P.; Liang, K-Y.; Zeger, SL. Analysis of Longitudinal Data. New York: Oxford University Press; 2002.

18 Tooze JA, Grunwald GK, Jones RH. Analysis of repeated measures data with clumping at zero. Statistical Methods in Medical Research. 2002; 11:341–355. [PubMed: 12197301]

19 Jeffrey S. Harman, Christy H. Lemak, Mona Al-Amin, Allyson G. Hall, and Robert Paul Duncan, Changes in Per Member Per Month Expenditures after Implementation of Florida’s Medicaid Reform Demonstration, Health Services Research 2010.01226

Idealized Representation of DD Method:



4. Propensity Score Matching: Propensity score matching is a technique developed to mimic randomization in observational studies like the SDC Pilot evaluation. A propensity score is the probability that an individual would be assigned to the treatment (SDC) versus comparison group conditioned on a set of observed covariates, such as demographics, diagnosis, service utilization history, and other factors. An advantage to propensity score matching is that a large set of potentially confounding covariates can be included without a loss of observations. This method will be applied in the design phase with application for a variety of causal models. The propensity scores will be estimated using logistic regression, with the outcome being SDC participation, and predictors being derived from an array of demographic, clinical, and social indicator constructs. The potential confounders, including age, race, gender, health status, housing status, and other variables should be selected a priori based on subject matter knowledge and in consultation with subject matter experts. Matching will also be done on timing of assessments. A greedy matching algorithm with an appropriate matching ratio of SDC participants to not SDC participants (1:n) will be used to create a matched analytic cohort based on the estimated propensity score^{20,21}. Balance in covariate distribution between SDC participants and not SDC participants in the matched analytic cohort will be assessed with weighted standardized difference²². The matched cohorts will be used for the quantitative methods indicated above.

Consumer Survey

The broader evaluation of the HARP Managed Care enrollment program has developed a member survey, the HARP Perception of Care Survey (PCS) (see Attachment D) designed to measure experience with care, perception of care, and perception of quality of life. Although members enrolled in HARPs and BH HCBS eligible members enrolled in HIV SNPs are being surveyed annually through a random sampling, all SDC participants in the pilot program are asked to complete the survey annually.

During the development of the HARP PCS, several validated instruments intended to assess consumer perception of the performance of health plans and BH services were reviewed. The HARP PCS was derived from those instruments. Specifically, questions were drawn from the Experience of Care and Health Outcomes (ECHO) Survey, the Mental Health Statistics Improvement Program (MHSIP) Survey, the Personal Wellbeing Index adult version (PWI-A), and the Maryland Outcomes Measurement System. The OMH also formulated

²⁰ Austin PC, Grootendorst P, Anderson GM. A comparison of the ability of different propensity score models to balance measured variables between treated and untreated subjects: a Monte Carlo study. *Stat Med* 2007; 26(4): 734–753. DOI: 10.1002/sim.2580

²¹ Macro %gmatch. Available at: <http://mayoresearch.mayo.edu/mayo/research/biostat/sasmacros.cfm>. Accessed September 15, 2011.

²² Austin PC. Assessing balance in measured baseline covariates when using many-to-one matching on the propensity-score. *Pharmacoepidemiol Drug Saf* 2008; 17(12): 1218–1225. DOI: 10.1002/pds.1674

questions for pertinent topic areas where none could be found in existing instruments. The majority of questions address domains of member experience, such as accessibility of services, quality of services, and appropriateness of care, wellness, quality of life, and social connectedness. Additionally, a set of socio-demographic questions are included that will allow examination of disparities.

The HARP PCS was piloted by OMH in the fall of 2016 with eight (8) (four [4] OMH and four [4] OASAS) funded BH programs. Peers and staff at the programs received training on survey administration from OMH. Feedback was gathered from pilot participants about the length of the survey, clarity of the questions, and relevance of the questions. Results from the pilot were analyzed and the final version of the survey developed. Initial administration to random samples of HARP enrollees was conducted in the fourth quarter of 2017 and will be continued annually. The survey is being implemented using two (2) random samplings of HARP enrollees. One random sample selects service providers who serve at least 15 HARP members in mental health or SUD specialty services; all HARP members receiving the service are surveyed. A second random sample uses direct mailing to HARP members. Over 3,000 HARP members were asked to complete the survey in 2017. The survey consists of 61 questions and is found in Attachment D.

Qualitative Methods

The process evaluation will address Goal 1 through collection of documentation, administrative data, and qualitative data from key informant interviews and focus groups. Documentation will include program specification, policy, and related documents developed by OMH, OASAS, SDC Advisory Council, fiscal and administrative entities, and pilot site agencies. Topics will include descriptions of administrative and fiscal intermediaries and pilot site agencies, how they were selected, and their operations; structure, membership, and meeting minutes of the SDC Advisory Council; eligibility criteria and recruitment strategies; credentialing, hiring, training and supervision of support brokers; budget allocations and financial rules including authorized and prohibited goods and services; and fiscal approval processes. Administrative data routinely collected from the fiscal and administrative intermediaries and the pilot agencies will also be used to describe ongoing processes between participants, support brokers, and administrative bodies.

For example, the process of participants working with support brokers to develop budgets based on recovery goals, requesting and receiving approval and funds from the administrative and fiscal intermediaries, and documenting final purchases is being recorded in an application with data that can be made available to the Contractor.

Key informant interviews will be held with key personnel from the OMH Bureau of Program and Policy Development; SDC Advisory Council; and the fiscal intermediary. Site visits to each pilot site will be scheduled in order to conduct focus groups with at least a subset of SDC participants depending on the numbers enrolled²³. At a minimum, one (1) to three (3) focus groups will be scheduled at each site involving around 10 participants each for a total of 10 to 30 participants. Site agencies will be asked to help recruit participants to focus groups. Focus group topics will include participant perceptions about the process of developing recovery plans and budgets; relationships between participants and support brokers; satisfaction with health and BH services; and SDC impact on participant recovery and quality of life. Interviews will also be scheduled with support brokers, and leadership and supervisory staff at the pilot site agencies. Topics will include relationships with administrative and fiscal intermediaries; credentialing, hiring, training and supervision of support brokers; budget allocations and financial rules including authorized and prohibited goods and services; process of recovery plan and budget development and purchasing of goods and services; relationships between SDC participants, Support Brokers and other staff; and facilitators and challenges of pilot program implementation. Key informant interviews and focus groups will be conducted using semi-structured protocols.

²³ Kaplowitz, M.D., and Hoehn, J.P. (2001). Do focus groups and individual interviews reveal the same information for natural resource valuation? *Ecological Economics* 36, 237-247.

Qualitative Analysis Method

The qualitative data analysis method will follow a framework described by Bradley, Curry, & Devers²⁴ that has been effectively used in health services research. This involves preliminary review of the data using a grounded theory approach (i.e., without predetermined categories) performed to identify emergent themes. A coding structure will then be established through an iterative process that labels concepts, relationships between concepts, and, if applicable, evaluative participant perspectives (i.e., statements that are positive, negative, or indifferent to their experiences or observations). Where appropriate (e.g., for interview data), the coding structure will also capture respondent characteristics (e.g., age, sex, support broker or position or role in organization) and setting (e.g., pilot site, region). Responses will then be re-reviewed independently by at least two (2) researchers, applying the finalized coding structure. Coding discrepancies between reviewers will be subsequently resolved through discussion to achieve consensus for the final coding of the data. Coded data will be analyzed and interpreted to identify major concept domains and themes.

Integration of Quantitative and Qualitative Methods

Findings from the quantitative and qualitative analyses will be integrated in order to refine and deepen the results from the different methods. Qualitative information from participant focus groups will be combined with quantitative findings on change indicators (Goal 2) to gain a more nuanced understanding of participant outcomes. In addition, barriers and facilitators of SDC implementation identified through the qualitative data and methods of the process evaluation will be combined with quantitative findings derived from the two (2) pilot sites to gain an understanding of whether there are elements critical to effective implementation.

Evaluation Design:

Goal 1: Implementation of a viable and effective SDC program for HARP enrolled/HCBS eligible individuals throughout NYS.

Question 1: What are the characteristics of SDC participants and how do they compare to the larger HARP and HCBS eligible population?

Hypotheses:

1. Members of HARP/HCBS population will be enrolled for participation in SDC at the two (2) pilot sites.

Question 2: What was the experience of HARP enrolled/HCBS eligible individuals participating in the SDC Pilot program in relation to satisfaction with the SDC program and its impact on their recovery, quality of life, and benefit from health and BH services?

Hypotheses:

1. Participants will gain experience with budgeting and using funds to meet recovery goals with resulting improvement in satisfaction with services, recovery, quality of life, and health/BH.

Question 3: What was the experience of non-participant stakeholders in the SDC Pilot program (e.g., Support Brokers, pilot site agency staff, State program development/oversight staff, fiscal intermediary) in relation to SDC implementation including State oversight and contracting, fiscal policies and procedures, hiring of SDC staff, recruitment and work with participants, and coordination with the fiscal intermediary?

Hypotheses:

1. OMH administrative staff will develop selection criteria, contract deliverables and procedures for ongoing monitoring for both pilot site agencies and the fiscal intermediary.
2. OMH administrative staff will develop fiscal policy and oversee fiscal intermediary and pilot site implementation.
3. Support brokers will be hired, trained and supervised by pilot sites and will interact with SDC participants and supervisory, fiscal intermediary and State oversight to facilitate SDC among participants.

²⁴ Bradley, A.H., Curry, L.A., and Devers, K.J. (2007). Qualitative data analysis for health services research: Developing taxonomy, themes, and theory. *Health Services Research*, 42(4), 1758-1772.

4. Pilot sites will work within OMH administrative policy to recruit, enroll, and facilitate ongoing participation in SDC.
5. Fiscal intermediary will develop a web based system for entering, approving and monitoring participant spending and will provide customer service to support brokers and SDC participants.

Question 4: What were the facilitators and challenges to SDC Pilot implementation and how would they impact statewide roll-out?

Hypotheses:

1. State oversight, pilot site agencies, and SDC participants will encounter both opportunities and barriers in the SDC process.

Methods:

To address Goal 1, the Contractor will use Quantitative Method 1 (Descriptive Statistics) to address Question 1 by describing the characteristics and service utilization patterns of SDC participants and how they compare to the larger HARP enrolled/HCBS eligible population. The remaining questions under Goal 1 will be addressed using the qualitative methods described above.

Q #	Implementation Indicator	Measure	Data Source	Hypotheses	Methods
1	SDC participant enrollment	Count SDC participants stratified by demographic, clinical, health, and functional characteristics	Pilot site enrollment BH HCBS Eligibility Assessment HARP PCS Medicaid claims	Members of HARP/HCBS population will be enrolled for participation in SDC at the two (2) pilot sites	Descriptive analysis of pilot site enrollment data Descriptive analysis of CMH Screen, HARP PCS, and Medicaid claims data comparing SDC enrollees to larger HARP/HCBS population
2	SDC participant recovery, quality of life, health, and BH services	Describe participant perspectives on SDC program, staff and process; impacts on their recovery, quality of life, health and BH; satisfaction with services	Transcripts of SDC participant focus groups	Participants will gain experience with budgeting and using funds to meet recovery goals with resulting improvement in satisfaction with services, recovery, quality of life, and health/BH	Qualitative analysis of themes and concepts derived from transcripts of focus groups
3	State oversight and contracting	Describe program policies regarding the selection, agreements made and ongoing monitoring of SDC sites and	OMH administrative documentation OMH administrative staff interviews	OMH administrative staff will develop selection criteria, contract deliverables and procedures for ongoing	Description of OMH policies regarding SDC program implementation Qualitative analysis of

Q #	Implementation Indicator	Measure	Data Source	Hypotheses	Methods
		fiscal intermediary		monitoring for both pilot site agencies and the fiscal intermediary	themes and concepts from interviews
3	Fiscal policies and procedures	Describe program policies regarding participant eligibility criteria, budgeting/use of funds, conflict of interest, and complaint/incident handling	OMH administrative documentation OMH administrative staff interviews Pilot site staff interviews	OMH administrative staff will develop fiscal policy and oversee fiscal intermediary and pilot site implementation	Description of OMH policies regarding SDC program implementation and fiscal policy Qualitative analysis of themes and concepts from interviews
3	SDC support broker and supervisory staff hiring and training	Describe support broker and supervisory staff demographics, credentials, training, supervision and their perspectives on the pilot program and their relationship with participants and fiscal and State oversight	Pilot site documentation on hiring, training, and supervising of support brokers Transcripts from interviews with support brokers, pilot site agency leadership/supervisory, fiscal intermediary, and State oversight staff	Support brokers will be hired, trained and supervised by pilot sites and will interact with SDC participants and supervisory, fiscal intermediary and State oversight to facilitate SDC among participants	Description of documentation regarding the hiring, training and supervision of support brokers for each site Qualitative analysis of themes and concepts derived from interviews
3	SDC participant recruitment, enrollment, and program participation	Describe pilot site agencies process for recruiting participants, educating participants about what SDC is and how they can participate, enrolling participants and facilitating ongoing participation	Pilot site administrative documents Pilot site staff interviews SDC participant focus groups	Pilot sites will work within OMH administrative policy to recruit, enroll, and facilitate ongoing participation in SDC	Description of pilot site policies regarding SDC program implementation Qualitative analysis of themes and concepts from interviews and focus groups
3	Fiscal intermediary practices and coordination	Describe fiscal intermediary's policy and infrastructure for providing payments, monitoring payments and supporting customers	Fiscal intermediary administrative and technical documents Interviews with fiscal intermediary staff, pilot site staff, State oversight staff	Fiscal intermediary will develop a web based system for entering, approving and monitoring participant spending and will provide customer service to support	Description of fiscal intermediary's process for payments, monitoring and assisting support brokers and participants

Q #	Implementation Indicator	Measure	Data Source	Hypotheses	Methods
				brokers and SDC participants	Qualitative analysis of themes and concepts from interviews
4	Facilitators and challenges to SDC pilot implementation	Identify and describe facilitators and challenges to the implementation of the SDC Pilot program	Interviews with State oversight, fiscal intermediary, pilot site agency staff Focus groups with participants	State oversight, pilot site agencies, and SDC participants will encounter both opportunities and barriers in the SDC process	Qualitative analysis of themes and concepts from interviews and focus groups

Goal 2: Improvement in recovery, health, BH, social functioning and satisfaction with care for SDC participants

Question 1: Do HARP members have improved quality of life after participating in SDC?

Hypotheses:

1. Quality of life will improve between baseline and three (3) year and subsequent follow-up for SDC participants.

Question 2: Do HARP members show improved indicators of health, BH and wellness after participating in SDC?

Hypotheses:

1. Indicators of BH will improve between baseline and three (3) year and subsequent follow-up for SDC participants.
2. Health indicators will improve between baseline and three (3) year and subsequent follow-up for SDC participants.

Question 3: Do HARP members show improvement in education and employment after participating in SDC?

Hypotheses:

1. Participation in employment and/or educational activities will increase between baseline and three (3) year and subsequent follow-up for SDC participants.

Question 4: Do HARP members show improvement in community tenure (i.e., maintaining stable long-term independence in the community) after participating in SDC?

Hypotheses:

1. Stability in the community will improve between baseline and three (3) year and subsequent follow-up for SDC participants.

Question 5: Do HARP members show improvement in social connectedness after participating in SDC?

Hypotheses:

1. Social connectedness will increase between baseline and three (3) year and subsequent follow up for SDC participants.

Question 6: Do HARP members report increased satisfaction with health and BH services after participating in SDC?

Hypotheses:

1. Satisfaction with care for BH services will improve between baseline and three (3) year and subsequent follow up for SDC participants.

Methods:

To address Goal 2, the Contractor will assess changes in outcomes for SDC participants between baseline and multiple follow up points over the first two (2) years of the pilot program (January 1, 2018-December 31, 2019) using data from the CMH Screen and HARP PCS. Follow up points are based on individual readmissions of the CMH Screen or HARP PCS. The GLMM models (Quantitative Method 2) will be used at these allow time points to vary both in number and spacing, and also adjust for correlation between measures taken at different time points for an individual. This approach will assess average trends on outcome measures derived from the CMH Screen and HARP PCS for SDC participants while controlling for possible confounding factors. Data from the PSM comparison group will be included to examine differences for HARP members participating in SDC versus those who are not, on Research Questions 2-5 using data from CMH. HARP PCS data, which Research Questions 1 and 6 rely upon, are not available for comparison group analyses.

Q#	Outcome Indicator	Measure	Data Source	Hypotheses	Methods
1	Participant quality of life	Life satisfaction scale Quality of life scale	HARP PCS	Quality of life will improve between baseline and three (3) year and subsequent follow-up for SDC participants	GLMM
2	Participant BH	Tobacco use, alcohol use, illegal drug use, misuse of prescription medications, difficulty due to substance use, and reduced ideation/acts of harm to self/others	BH HCBS Eligibility Assessment HARP PCS	Indicators of BH will improve between baseline and three (3) year and subsequent follow-up for SDC participants	GLMM
2	Participant physical health	Health status, difficulty due to physical health	CMH Screen HARP PCS	Health indicators will improve between baseline and three (3) year and subsequent follow-up for SDC participants	GLMM
3	Participant employment and participation in education	Employment status, hours worked in competitive employment, educational status, and enrollment in educational program	CMH Screen HARP PCS	Participation in employment and/or educational activities will increase between baseline and three (3) year and subsequent follow-up for SDC participants	GLMM
4	Participant community tenure and stability	Residential status/housing stability; arrest, incarceration, other legal involvement; Assisted Outpatient	CMH Screen HARP PCS	Stability in the community will improve between baseline and three (3) year and subsequent follow-	GLMM

Q#	Outcome Indicator	Measure	Data Source	Hypotheses	Methods
		Treatment (AOT) order; functional independence		up for SDC participants	
5	Participant social connection	Social relationship strengths, level of social activity	CMH Screen	Social connectedness will increase between baseline and three (3) year and subsequent follow up for SDC participants	GLMM
6	Participant satisfaction	Quality of care, helpfulness of services	HARP PCS	Satisfaction with care for BH services will improve between baseline and three (3) year and subsequent follow up for SDC participants	

Goal 3: Maintenance of Medicaid cost neutrality overall and reduction of BH inpatient and crisis service utilization and cost for SDC participants.

Question 1: Does participation in SDC result in increased use and cost of outpatient BH services and primary care?

Hypotheses:

1. Outpatient BH service use will increase between baseline and three (3) year and subsequent follow up for SDC participants.
2. Use of primary care will increase between baseline and three (3) year and subsequent follow up for SDC participants.

Question 2: Does participation in SDC result in decreased use and cost of BH inpatient, ED and crisis services?

Hypotheses:

1. Inpatient stays for BH will decrease between baseline and three (3) year and subsequent follow up for SDC participants.
2. ED and BH crisis service use will decrease between baseline and three (3) year and subsequent follow-up for SDC participants.

Question 3: How does participation in SDC impact overall Medicaid spending?

Hypotheses:

1. Spending on BH outpatient services (including non-traditional services) will increase between baseline and three (3) year and subsequent follow up for SDC participants.
2. Spending on primary care will increase between baseline and three (3) year and subsequent follow up for SDC participants.
3. Spending on ED and BH inpatient and crisis service use will decrease between baseline and three (3) year and subsequent follow up for SDC participants.
4. Overall Medicaid spending will stay the same between baseline and three (3) year and subsequent follow up for SDC participants.

Methods:

To address Goal 3, a more rigorous approach will be used to identify change in Medicaid service utilization and spending patterns using a DD analysis (Quantitative Method 3). The DD analysis will employ the quasi-experimental comparison group derived using Propensity Score Matching (Quantitative Method 4). The DD analysis will assess how change in service use and cost for SDC participants from the pre-period before SDC participation to the post-period compares to patterns in the same timeframes for the comparison group.

Q#	Outcome Indicator	Measure	Data Source	Hypotheses	Methods
1	Participant use of outpatient BH services	Claims for BH outpatient services	Medicaid claims and encounters	Outpatient BH service use will increase between baseline and three (3) year and subsequent follow up for SDC participants	DD
1	Participant use of primary care	Claims for primary care visits	Medicaid claims and encounters	Use of primary care will increase between baseline and three (3) year and subsequent follow up for SDC participants	DD
2	BH inpatient stays	Rates of admissions and days for BH inpatient stays	Medicaid claims and encounters OMH State Psychiatric Center records (Mental Health Acute Response Service [MHARS])	Inpatient stays for BH will decrease between baseline and three (3) year and subsequent follow up for SDC participants	DD
2	Use of ED and BH crisis services	Rates of BH ED use Rates of non-BH ED use Rates of BH crisis service use	Medicaid claims and encounters	ED and BH crisis service use will decrease between baseline and three (3) year and subsequent follow-up for SDC participants	DD
3	Spending on BH outpatient services	Cost per member per month of BH outpatient services	Medicaid claims and encounters	Spending on BH outpatient services (including non-traditional services) will increase between baseline and	DD

Q#	Outcome Indicator	Measure	Data Source	Hypotheses	Methods
				three (3) year and subsequent follow up for SDC participants	
3	Spending on primary care	Cost per member per month of primary care	Medicaid claims and encounters	Spending on primary care will increase between baseline and three (3) year and subsequent follow up for SDC participants	DD
3	Spending on ED, BH inpatient and crisis service use	Cost per member per month of ED use, and BH inpatient and crisis services	Medicaid claims and encounters	Spending on ED and BH inpatient and crisis service use will decrease between baseline and three (3) year and subsequent follow up for SDC participants	DD
3	Overall Medicaid spending	Overall Medicaid cost per member per month	Medicaid claims and encounters	Overall Medicaid spending will stay the same between baseline and three (3) year and subsequent follow up for SDC participants	DD

Expanded Evaluation Plan

Although the Contractor will present their evaluation plan in their Technical Proposal in accordance with the scope of work above, an Expanded Evaluation Plan for each of the two (2) evaluations will be due from the Contractor within two (2) months of the contract start date. The Expanded Evaluation Plan will be one comprehensive document that includes the evaluation requirements from this RFP, the evaluation plan from the Contractor's Technical Proposal, and any additional details determined after an orientation is provided by the New York State Department of Health and in accordance with the CMS Special Terms and Conditions (STC). The Expanded Evaluation Plans will be submitted by the New York State Department of Health to CMS, any questions will be answered and edits made by the Contractor, and then the Expanded Evaluation Plans will be posted on the New York State Department of Health website upon CMS approval.

Cooperation with Federal Evaluators

As per the STC, should the United States Department of Health and Human Services (HHS) undertake an evaluation of any component of the Demonstration, the Contractor is expected to cooperate, to the greatest extent possible, fully with CMS or the evaluator selected by HHS. Requests for information and data shall be made in a timely manner.

Data sources to be used in the evaluation, to be made available to the selected Contractor upon request, include:

Data Sources for HARP Evaluation:

Medicaid Choice Enrollment Data NY: New York's enrollment broker, New York Medicaid Choice, is collecting information to track the HARP enrollment process. The number of announcement, passive enrollment, and opt out acknowledgement letters distributed, number of announcement, passive enrollment, and opt out

acknowledgement letters returned, number of members enrolled, number of members who opt out, and reasons for opting out are collected on an ongoing basis.

ONTrackNY Data System: The OnTrackNY teams complete data collection forms to provide information on client outcomes and program functioning/services. Information about individual clients is collected through a referral tracking form, an admission form, follow-up forms (submitted quarterly), and a discharge form. Team-level information such as staffing, functioning, and caseload is collected via a quarterly program components form.

- Referral tracking form: referring organization and relationship to potential client, outcome of referral (eligibility evaluation results, declined or enrolled in OnTrackNY).
- Admission form: demographic information (Date of Birth [DOB], gender, race, marital status, primary language), educational background (highest grade, current status of school enrollment), employment status and history (currently employed or not, job/internship history), family background (education, employment status, primary language of primary support person), previous psychiatric treatment (psychiatric hospitalizations and psychotropic medications prescribed), medical and substance use history, Mental Illness Research, Education, and Clinical Center [MIRECC] Global Assessment of Functioning [GAF] score (symptom, occupational functioning and social functioning scale).
- Follow-up form: current primary diagnosis, service utilization (met with SEES (Supported Education and Employment Specialist), list of core sessions completed, current antipsychotic medications and side effects evaluation, education and employment status during the assessment period, substance use and behavioral concerns (violent behavior, suicide attempts), MIRECC GAF score
- Discharge form: reason for discharge and post discharge services arranged, education and employment status, antipsychotic medications at time of discharge, staff perspective on client outcomes (whether client's goals for education/employment/symptom management were met), MIRECC GAF score
- Program components form: staffing (Full Time Equivalent [FTEs] devoted to team), number of team meetings and percentage of time spent on SEES (Supported Education and Employment Specialist)-related activities, recruitment and evaluation activities (number of individuals contacted the program, number of individuals who began eligibility evaluation, number of individuals who were determined to be eligible).

The State is working to develop a Medicaid claims based algorithm which will be tested in collaboration with Mainstream MMC plans to develop capacity to identify incident cases of FEP using claims and potentially EHR data. This methodology is emergent at this time. The State anticipates that over the course of the demonstration period that the identification of incident cases of FEP will become more robust.

MMC HCBS Provider Network Data System: The OMH maintains a database containing information on providers who applied to provide BH HCBS. The database contains provider contact information, provider location, specific service(s) provided, staff qualifications, and funding information. The OMH also will collect from MMC plans a list of BH HCBS providers that plans have contracted with.

Medicaid Claims and Encounters: The Medicaid Data Warehouse contains billing records for health care services, including pharmacy, for individuals enrolled in Medicaid in a given year. Also included are data on Medicaid enrollment status, diagnoses and provider associated with the billed services. The Medicaid Data Warehouse will receive data from all managed care plans providing services to the demonstration population. Given the claims processing, there is a six (6)-month lag in the availability of complete and finalized Medicaid claims data, where data for a given year are considered final by June 30 of the following year.

CAHPS®: The Health Plan version of the CAHPS® survey will be administered to adults by DOH every other year during the demonstration period and will serve as the data source for selected member experience measures. The survey is administered by both mail and telephone, and assesses patients' experiences with health care providers and health plan staff. This includes information on patient experience with access to care, experiences with health care providers and health plan support. The survey includes standardized questionnaires for adults and children. Given confidentiality agreements, only de-identified CAHPS data will be available for use. Data will be self-reported and from a sample of MMC members. The experiences of the survey respondent population may be

different than those of non-respondents with respect to their health care services. Therefore, data users should consider the potential for non-response bias when interpreting CAHPS results.

Community Mental Health Assessment (CMHA) (BH HCBS Eligibility Brief Assessment and BH HCBS Full Assessment): The Uniform Assessment System (UAS) contains the BH HCBS Eligibility Brief Assessment and BH HCBS Full Assessment data on HARP eligible individuals enrolled HARPs or HIV SNPs. Data include patient functional status, living situation, employment, education, BH status, health status, cognitive functioning, and care preferences. The assessments include comprehensive sections on mental health state and substance use behaviors, including the following domains: mental state indicators, substance use or excessive behaviors, harm to self and others, behavior, cognition, stress and trauma. In terms of social functioning, the assessments include comprehensive sections on: cognition, functional status, social relations, employment, education and finances, and environmental assessment. Data are a mix of self-reported information and information that is available to assessors through the care management process. Data users should consider the potential for self-reported items to be inaccurate.

HEDIS®/QARR Plan Reported Metrics: MMC plans, HARPs, and HIV SNPs will report HEDIS®/QARR data to DOH annually. To supplement the QARR measurement set, the State will produce BH Medicaid Outcome Measures at least annually. These reports will be based on Medicaid claims data and include measures related to inpatient discharge events and also measures related to outpatient care. The State accesses data in the Medicaid Data Warehouse. The measures will cover both the mental health and SUD populations. Starting in the first year of implementation, metrics will be produced for the HARP and Mainstream MMC plans. Change over time in the above HEDIS®/QARR and NYS BH Medicaid Outcome Measures will be examined.

Where there are gaps in HEDIS®/QARR utilization data, the State will produce service utilization measures. The State will monitor utilization of BH services beginning in the first year of implementation. Monitoring will consist of utilization of services, cost, and encounter volume by BH service. This monitoring will allow the State to determine if services are being provided at an appropriate volume. It is important that the transition of BH services into managed care does not disrupt members' treatment. These reports will also allow the State to monitor utilization of the new BH HCBS.

HARP PCS: The HARP members enrolled in HARP or HIV SNP plans will be surveyed to measure perception of care and quality of life outcomes. The survey will be implemented by the EQRO using a random sampling methodology of HARP enrollees by product line for HARPs and HIV SNPs. The first survey was piloted in early 2017. The survey instrument consists of approximately 50 questions and is mailed to a random sample of eligible HARP members. Methods to improve response rate (e.g., web and mail survey administration, administration by peer advocates, sending reminders) from this representative sample are under review. Demographics are collected, which will allow HARPs to monitor disparities. Data from this survey will allow the State and plans to monitor HARP members' perception of services and how their BH services affect different areas of their life. Specific survey domains include Perception of Outcomes, Daily Functioning, Access to Services, Appropriateness of Services, Social Connectedness, and Quality of Life. Findings will be examined for change in BH services satisfaction levels over time. Data will be self-reported and from a sample of HARP members. The experiences of the survey respondent population may be different than those of non-respondents with respect to their health care services. Therefore, data users should consider the potential for non-response bias when interpreting HARP PCS results.

Data Sources for SDC Pilot Evaluation:

Pilot Site Enrollment Data: OMH has designed a secure web application for use by SDC participants and Support Brokers to develop and manage SDC budgets based on personal recovery plans and goals. Data from this application includes SDC enrollment information by site and recovery goal-related expenditures. The application data can be linked to Medicaid claims data.

Medicaid Claims and Encounters: See HARP Evaluation Data Sources

Community Mental Health Assessment (CMHA) (BH HCBS Eligibility Brief Assessment and BH HCBS Full Assessment): See HARP Evaluation Data Sources

HARP PCS: See HARP Evaluation Data Sources. All SDC participants are administered the HARP PCS survey annually.

NYS OMH Psychiatric Center Records: The OMH maintains the MHARS for episodes of inpatient, residential, and outpatient care in NYS Psychiatric Centers. These data will be used to identify psychiatric inpatient stays not included in Medicaid claims data.

Data Access and Security

For those data sources identified above that are not housed on intranet network drives (i.e., Medicaid Data Warehouse and NYSoH Enrollment data), the Contractor will be granted user rights to access the systems for this evaluation. Because the periodicity of data refresh varies across sources/systems, the most recently available data cycles may be inconsistent and adjustments will be made to ensure evaluation periods are consistent and thoroughly explained.

The Department will provide the Contractor with a Virtual Private Network (VPN) connection, privileges, and login ID(s) that provide secure access to the appropriate NYS Medicaid systems and data, to perform the scope of work under this agreement. The Contractor will need information technology staffing (e.g., a programmer) to facilitate data access. The Contractor shall provide a signed copy of a Data Use Agreement (DUA), specifying the data scope, including but not limited to, data elements and date range of the data needed. The Contractor shall be provisioned accounts for authorized users to access the required data in the NYS provided environment in accordance with the terms and conditions of the contract and for the duration of the DUA. Upon award, the Contractor will provide the Department, and maintain on an ongoing basis, the list of those users, including name, position, responsibility, and time period, who will require access to the data. The Contractor must review, update, and submit a list of current authorized users to the Department quarterly. Additionally, the Contractor must notify the Department immediately, in accordance with the DUA, when an authorized user joins or separates from the project. The Department will authorize users and provision accounts within 30 calendar days of request.

Given public health law and/or DUAs that govern access to these data, bidders for the Independent Evaluation should be aware that obtaining access will require substantial time and effort, which should be considered when developing the evaluation timeline.

4.2 Staffing Requirements

A successful evaluation project will rely on an effective organizational structure and highly productive, motivated, and qualified staff. Overall project staffing should adequately meet the project activities and deliverables. Staff are expected to have appropriate training and experience in program evaluation, quantitative data collection and analysis using large and complex data systems, statistical programming and analysis, survey and interview development, qualitative data collection and analysis, data programming and software (to facilitate data access), and report preparation.

The Contractor is required to have a full-time (30 hours per week or greater) project manager for both of the two (2) evaluations who will assure effective communication and coordination of the Independent Evaluation projects, including integrity of all products and integrating information from all aspects of the evaluation throughout the course of the contract period. The Contractor is also required to have a technical writer who will assure that all written products are professionally prepared, clear, accurate, and meaningful.

Within 30 calendar days of notice of award, the Selected Bidder will submit resumes of the staff proposed in the staffing plan (see Section D5.) for review and approval by the New York State Department of Health. In the event that a staff member becomes unavailable during the contract period, the Contractor will submit resumes within 10 business days of notification of the staff unavailability to the New York State Department of Health for review and approval prior to engaging work from the replacement on this contract.

4.3 Reporting Requirement

The Contractor is responsible for the following reports, which are expected to be written professionally, accurately, and by staff who are proficient with technical writing:

Evaluation Reports. The Evaluation Reports must be responsive to the STC outline requirement (see STC XI 2d). Per agreement between the New York State Department of Health and CMS, the two (2) separate reports for HARP and the SDC Pilot evaluations must contain evaluation results by the following due dates:

Activity	Due Date
Draft Due to New York State Department of Health for review	June 1, 2020
Draft Due for Posting to the New York State Department of Health Website	July 1, 2020
Revised Draft Due to New York State Department of Health for review	August 1, 2020
Final Due to New York State Department of Health for CMS	September 1, 2020

Upon CMS approval of the Evaluation Reports, the final reports will be posted on the New York State Department of Health website.

Monthly Progress Reports. The Contractor will provide written updates for each of the two (2) evaluations to the New York State Department of Health on data access, collection, analysis, and the status of other activities completed during the month, and any difficulties encountered. These reports are due by the seventh (7th) business day following the end of the month that is being reported on.

Weekly Project Meetings. The Contractor will participate in weekly conference call meetings with the New York State Department of Health (Office of Health Insurance Programs and Office of Quality and Patient Safety), Office of Mental Health, and Office of Alcoholism and Substance Abuse Services to communicate updates regarding the Independent Evaluation project, including progress made, challenges encountered, technical questions, presentation of individual analysis findings for technical feedback, and troubleshooting (e.g., data access). Frequency of meetings may be greater than weekly during the initial project start and some meetings (estimated at three (3) times during the contract) may be in person at the Department's Albany offices to better facilitate outcomes (e.g., orientations, initial data access).

Presentations for CMS. Additionally, in accordance with the STC, the Contractor will be expected to present to and participate in a discussion with CMS on the Expanded Evaluation Plans and the Evaluation Reports. These meetings are expected to be conference calls lasting no more than two (2) hours in length.

4.4 Information Technology

The application and all systems and components supporting it, including but not limited to any forms and databases that include Personal Health, Personal Identification or other New York State information, must comply with all NYS security policies and standards listed at <http://its.ny.gov/tables/technologypolicyindex.htm>.

4.5 Security

The Contractor shall comply with all privacy and security policies and procedures of the Department (<https://its.ny.gov/eiso/policies/security>) and applicable state and federal law and administrative guidance with respect to the performance of this contract. The Contractor is required, if applicable, to execute a number of security and privacy agreements with the Department including a Business Associate Agreement (Appendix H) and a Data Use Agreement (DUA) at contract signing.

The Contractor is expected to provide secure and confidential backup, storage and transmission for hard copy and electronically stored information. Under no circumstances will any records be released to any person, agency, or organization without specific written permission of the DOH. The Contractor is obligated to ensure any Subcontractor hired by Contractor who stores, processes, analyzes or transmits MCD on behalf of Contractor has the appropriate Security requirements in place. Contractor is required to include in all contracts and Business Associate Agreements with their Subcontractors language surrounding the security and privacy requirements as well as the language contained in the Confidentiality Language for Third Parties section of the DUA. If any breach

or suspected breach of the data or confidentiality occurs, whether the breach occurred with the Contractor or Subcontractor, DOH must be notified immediately.

The Contractor is required to maintain and provide to the Department upon request their data confidentiality plans and procedures for meeting security requirements as they relate to the deliverables and services within this RFP, including all plans as they relate to Subcontractor work where applicable.

The Contractor will develop and maintain adequate fully trained staff to respond to all stakeholder inquiries while protecting confidentiality and maintaining the security and integrity of all systems. Staff must be trained to understand and observe requirements related to confidentiality and operating guidelines for functions included in this RFP.

The Contractor will comply fully with all current and future updates of the security procedures of the DOH/HRI, as well as with all applicable State and federal requirements, in performance of this contract.

4.6 Transition

The Contractor is required to develop a plan to securely and smoothly transfer any records referenced in this section to the Department or another Department agent should that be required during or upon expiration of its contract. The plan and documentation must be submitted to the Department no later than four (4) months after contract execution.

The Contractor shall provide technical and business process support as necessary and required by the Department to transition and assume contract requirements to the Department or another Department agent should that be required during or at the end of the contract.

5.0 ADMINISTRATIVE INFORMATION

The following administrative information will apply to this RFP. Failure to comply fully with this information may result in disqualification of your proposal.

5.1 Restricted Period

“Restricted period” means the period of time commencing with the earliest written notice, advertisement, or solicitation of a Request for Proposals (“RFP”), Invitation for Bids (“IFB”), or solicitation of proposals, or any other method for soliciting a response from Bidders intending to result in a procurement contract with DOH and ending with the final contract award and approval by DOH and, where applicable, final contract approval by the Office of the State Comptroller.

This prohibition applies to any oral, written, or electronic communication under circumstances where a reasonable person would infer that the communication was intended to influence this procurement. Violation of any of the requirements described in this Section may be grounds for a determination that the bidder is non-responsible and therefore ineligible for this contract award. Two (2) violations within four (4) years of the rules against impermissible contacts during the “restricted period” may result in the violator being debarred from participating in DOH procurements for a period of four (4) years.

Pursuant to State Finance Law §§ 139-j and 139-k, the Department of Health identifies a designated contact on face page of this RFP to whom all communications attempting to influence this procurement must be made.

5.2 Questions

There will be an opportunity available for submission of written questions and requests for clarification with regard to this RFP. All questions and requests for clarification of this RFP should cite the particular RFP Section and paragraph number where applicable and must be submitted via email to OQPS.ASU@health.ny.gov. It is the bidder’s responsibility to ensure that email containing written questions and/or requests for clarification is received at the above address no later than the Deadline for Submission of Written Questions as specified in Section 1.0 (Calendar of Events). Questions received after the deadline may **not** be answered.

5.3 Letter of Intent to Bid

Although not mandatory, the New York State Department of Health requests submission of a Letter of Intent to Bid to assist the Department in better managing the procurement process. Please submit a Letter of Intent to Bid to the Permissible Subject Matter Contact listed on the cover page of this RFP by the date indicated in Section 1.0, Calendar of Events. The Letter of Intent can be submitted via email or mailed hard copy. The Letter of Intent should include the name and number of the RFP, and contact information (name, title, address, telephone, and email address) of the Bidder's official representative.

5.4 Right to Modify RFP

DOH reserves the right to modify any part of this RFP, including but not limited to, the date and time by which proposals must be submitted and received by DOH, at any time prior to the Deadline for Submission of Proposals listed in **Section 1.0** (Calendar of Events). Modifications to this RFP shall be made by issuance of amendments and/or addenda.

Prior to the Deadline for Submission of Proposals, any such clarifications or modifications as deemed necessary by DOH will be posted to the DOH website.

If the bidder discovers any ambiguity, conflict, discrepancy, omission, or other error in this RFP, the Bidder shall immediately notify DOH of such error in writing at OQPS.ASU@health.ny.gov and request clarification or modification of the document.

If, prior to the Deadline for Submission of Proposals, a bidder fails to notify DOH of a known error or an error that reasonably should have been known, the bidder shall assume the risk of proposing. If awarded the contract, the bidder shall not be entitled to additional compensation by reason of the error or its correction.

5.5 Payment

The contractor shall submit invoices and/or vouchers to the State's designated payment office:

Preferred Method: Email a .pdf copy of your signed voucher to the BSC at: AccountsPayable@ogs.ny.gov with a subject field as follows:

Subject: Unit ID: 3450449 Contract #: (to be determined)

Alternate Method: Mail vouchers to BSC at the following U.S. postal address:

**NYS Department of Health
Unit ID 3450449
c/o NYS OGS BSC Accounts Payable
Building 5, 5th Floor
1220 Washington Ave.
Albany, NY 12226-1900**

Payment for invoices and/or vouchers submitted by the CONTRACTOR shall only be rendered electronically unless payment by paper check is expressly authorized by the Commissioner, in the Commissioner's sole discretion, due to extenuating circumstances. Such electronic payment shall be made in accordance with ordinary State procedures and practices. The CONTRACTOR shall comply with the State Comptroller's procedures to authorize electronic payments. Authorization forms are available at the State Comptroller's website at www.osc.state.ny.us/epay/index.htm, by email at epayments@osc.state.ny.us or by telephone at 518-474-6019. CONTRACTOR acknowledges that it will not receive payment on any invoices and/or vouchers submitted under this Contract if it does not comply with the State Comptroller's electronic payment procedures, except where the Commissioner has expressly authorized payment by paper check as set forth above.

In addition to the Electronic Payment Authorization Form, a Substitute Form W-9 must be on file with the Office of the State Comptroller, Bureau of Accounting Operations. Additional information and procedures for enrollment can be found at <http://www.osc.state.ny.us/epay>.

Completed W-9 forms should be submitted to the following address:

NYS Office of the State Comptroller
Bureau of Accounting Operations
Warrant & Payment Control Unit
110 State Street, 9th Floor
Albany, NY 12236

Payment of such invoices and/or vouchers by the State (NYS Department of Health) shall be made in accordance with Article XI-A of the New York State Finance Law. Vouchers should be submitted on a monthly basis and payment will be based on completion and approval of milestones in accordance with the Attachment B, Cost Proposal.

5.6 Minority & Woman-Owned Business Enterprise Requirements

Pursuant to New York State Executive Law Article 15-A, the New York State Department of Health (“DOH”) recognizes its obligation to promote opportunities for maximum feasible participation of certified minority-and women-owned business enterprises and the employment of minority group members and women in the performance of DOH contracts.

In 2006, the State of New York commissioned a disparity study to evaluate whether minority and women-owned business enterprises had a full and fair opportunity to participate in state contracting. The findings of the study were published on April 29, 2010, under the title "The State of Minority and Women-Owned Business Enterprises: Evidence from New York" (“Disparity Study”). The report found evidence of statistically significant disparities between the level of participation of minority-and women-owned business enterprises in state procurement contracting versus the number of minority-and women-owned business enterprises that were ready, willing and able to participate in state procurements. As a result of these findings, the Disparity Study made recommendations concerning the implementation and operation of the statewide certified minority- and women-owned business enterprises program. The recommendations from the Disparity Study culminated in the enactment and the implementation of New York State Executive Law Article 15-A, which requires, among other things, that DOH establish goals for maximum feasible participation of New York State Certified minority- and women – owned business enterprises (“MWBE”) and the employment of minority groups members and women in the performance of New York State contracts.

Business Participation Opportunities for MWBEs

For purposes of this solicitation, DOH hereby establishes an overall goal of **30%** for MWBE participation, **15%** for Minority-Owned Business Enterprises (“MBE”) participation and **15%** for Women-Owned Business Enterprises (“WBE”) participation (based on the current availability of qualified MBEs and WBEs and outreach efforts to certified MWBE firms). A contractor (“Contractor”) on the subject contract (“Contract”) must document good faith efforts to provide meaningful participation by MWBEs as subcontractors or suppliers in the performance of the Contract and Contractor agrees that DOH may withhold payment pending receipt of the required MWBE documentation. For guidance on how DOH will determine “good faith efforts,” refer to 5 NYCRR §142.8.

The directory of New York State Certified MWBEs can be viewed at: <https://ny.newnycontracts.com>. The directory is found in the upper right hand side of the webpage under “Search for Certified Firms” and accessed by clicking on the link entitled “MWBE Directory”. Engaging with firms found in the directory with like product(s) and/or service(s) is strongly encouraged and all communication efforts and responses should be well documented.

By submitting a bid, a bidder agrees to complete an MWBE Utilization Plan (Attachment 5, Form #1) of this RFP. DOH will review the submitted MWBE Utilization Plan. If the plan is not accepted, DOH may issue a notice of deficiency. If a notice of deficiency is issued, Bidder agrees that it shall respond to the notice of deficiency within seven (7) business days of receipt. DOH may disqualify a Bidder as being non-responsive under the following circumstances:

- a) If a Bidder fails to submit a MWBE Utilization Plan;
- b) If a Bidder fails to submit a written remedy to a notice of deficiency;
- c) If a Bidder fails to submit a request for waiver (if applicable); or
- d) If DOH determines that the Bidder has failed to document good-faith efforts;

The Contractor will be required to attempt to utilize, in good faith, any MBE or WBE identified within its MWBE Utilization Plan, during the performance of the Contract. Requests for a partial or total waiver of established goal requirements made subsequent to Contract Award may be made at any time during the term of the Contract to DOH, but must be made no later than prior to the submission of a request for final payment on the Contract.

The Contractor will be required to submit a Contractor's Quarterly M/WBE Contractor Compliance & Payment Report to the DOH, by the 10th day following each end of quarter over the term of the Contract documenting the progress made toward achievement of the MWBE goals of the Contract.

If the Contractor is found to have willfully and intentionally failed to comply with the MWBE participation goals set forth in the Contract, such finding will constitute a breach of Contract and DOH may withhold payment from the Contractor as liquidated damages.

Such liquidated damages shall be calculated as an amount equaling the difference between: (1) all sums identified for payment to MWBEs had the Contractor achieved the contractual MWBE goals; and (2) all sums actually paid to MWBEs for work performed or materials supplied under the Contract.

New York State certified Minority- and Women-Owned Businesses (M/WBE) may request that their firm's contact information be included on a list of M/WBE firms interested in serving as a subcontractor for this procurement. The listing will be publicly posted on the Department's website for reference by the bidding community. A firm requesting inclusion on this list should send contact information and a copy of its NYS M/WBE certification to OQPS.ASU@health.ny.gov before the Deadline for Questions as specified in Section 1.0 (Calendar of Events). Nothing prohibits an M/WBE Vendor from proposing as a prime contractor.

Please Note: Failure to comply with the foregoing requirements may result in a finding of non-responsiveness, non-responsibility and/or a breach of the Contract, leading to the withholding of funds, suspension or termination of the Contract or such other actions or enforcement proceedings as allowed by the Contract.

5.7 Equal Employment Opportunity (EEO) Reporting

By submission of a bid in response to this solicitation, the Bidder agrees with all of the terms and conditions of Attachment 8 Appendix A including Clause 12 - Equal Employment Opportunities for Minorities and Women. Additionally, the successful bidder will be required to certify they have an acceptable EEO (Equal Employment Opportunity) policy statement in accordance with Section III of Appendix M in Attachment 8.

Further, pursuant to Article 15 of the Executive Law (the "Human Rights Law"), all other State and Federal statutory and constitutional non-discrimination provisions, the Contractor and sub-contractors will not discriminate against any employee or applicant for employment because of race, creed (religion), color, sex, national origin, sexual orientation, military status, age, disability, predisposing genetic characteristic, marital status or domestic violence victim status, and shall also follow the requirements of the Human Rights Law with regard to non-discrimination on the basis of prior criminal conviction and prior arrest.

The Contractor is required to ensure that it and any subcontractors awarded a subcontract over \$25,000 for the construction, demolition, replacement, major repair, renovation, planning or design of real property and improvements thereon (the "Work"), except where the Work is for the beneficial use of the Contractor, undertake or continue programs to ensure that minority group members and women are afforded equal employment opportunities without discrimination because of race, creed, color, national origin, sex, age, disability or marital status. For these purposes, equal opportunity shall apply in the areas of recruitment, employment, job assignment, promotion, upgrading, demotion, transfer, layoff, termination, and rates of pay or other forms of

compensation. This requirement does not apply to: (i) work, goods, or services unrelated to the Contract; or (ii) employment outside New York State.

To ensure compliance with this Section, the Bidder should submit with the bid or proposal an Equal Employment Opportunity Staffing Plan (Attachment 5, Form #4) identifying the anticipated work force to be utilized on the Contract. Additionally, the Bidder should submit a Minority and Women-Owned Business Enterprises and Equal Employment Opportunity Policy Statement (Attachment 5, Form # 5), to DOH with their bid or proposal.

5.8 Sales and Compensating Use Tax Certification (Tax Law, § 5-a)

Section 5-a of the Tax Law, as amended, effective April 26, 2006, requires certain contractors awarded state contracts for commodities, services and technology valued at more than \$100,000 to certify to the Department of Tax and Finance (DTF) that they are registered to collect New York State and local sales and compensating use taxes. The law applies to contracts where the total amount of such contractors' sales delivered into New York State are in excess of \$300,000 for the four (4) quarterly periods immediately preceding the quarterly period in which the certification is made, and with respect to any affiliates and subcontractors whose sales delivered into New York State exceeded \$300,000 for the four quarterly periods immediately preceding the quarterly period in which the certification is made.

This law imposes upon certain contractors the obligation to certify whether or not the contractor, its affiliates, and its subcontractors are required to register to collect state sales and compensating use tax and contractors must certify to DTF that each affiliate and subcontractor exceeding such sales threshold is registered with DTF to collect New York State and local sales and compensating use taxes. The law prohibits the State Comptroller, or other approving agencies, from approving a contract awarded to an offerer meeting the registration requirements but who is not so registered in accordance with the law.

The successful Bidder must file a properly completed Form ST-220-CA with the Department of Health and Form ST-220-TD with the DTF. These requirements must be met before a contract may take effect. Further information can be found at the New York State Department of Taxation and Finance's website, available through this link: <http://www.tax.ny.gov/pdf/publications/sales/pub223.pdf>.

Forms are available through these links:

- ST-220 CA: http://www.tax.ny.gov/pdf/current_forms/st/st220ca_fill_in.pdf
- ST-220 TD: http://www.tax.ny.gov/pdf/current_forms/st/st220td_fill_in.pdf

5.9 Contract Insurance Requirements

Prior to the start of work under this Contract, the CONTRACTOR shall procure, at its sole cost and expense, and shall maintain in force at all times during the term of this Contract, insurance of the types and in the amounts set forth in Attachment 8, the New York State Department of Health Contract, Section IV. Contract Insurance Requirements.

5.10 Subcontracting

Bidder's may propose the use of a subcontractor. The Contractor shall obtain prior written approval from NYSDOH before entering into an agreement for services to be provided by a subcontractor. The Contractor is solely responsible for assuring that the requirements of the RFP are met. All subcontracts shall contain provisions specifying that the work performed by the subcontractor must be in accordance with the terms of the prime contract, and that the subcontractor specifically agrees to be bound by the confidentiality provisions set forth in the agreement between the DOH and the Contractor. DOH reserves the right to request removal of any bidder's staff or subcontractor's staff if, in DOH's discretion, such staff is not performing in accordance with the Agreement. Subcontractors whose contracts are valued at or above \$100,000 will be required to submit the Vendor Responsibility Questionnaire upon selection of the prime contractor.

5.11 DOH's Reserved Rights

The Department of Health reserves the right to:

1. Reject any or all proposals received in response to the RFP;
2. Withdraw the RFP at any time, at the agency's sole discretion;
3. Make an award under the RFP in whole or in part;
4. Disqualify any bidder whose conduct and/or proposal fails to conform to the requirements of the RFP;
5. Seek clarifications and revisions of proposals;
6. Use proposal information obtained through site visits, management interviews and the state's investigation of a bidder's qualifications, experience, ability or financial standing, and any material or information submitted by the bidder in response to the agency's request for clarifying information in the course of evaluation and/or selection under the RFP;
7. Prior to the bid opening, amend the RFP specifications to correct errors or oversights, or to supply additional information, as it becomes available;
8. Prior to the bid opening, direct bidders to submit proposal modifications addressing subsequent RFP amendments;
9. Change any of the scheduled dates;
10. Eliminate any mandatory, non-material specifications that cannot be complied with by all of the prospective bidders;
11. Waive any requirements that are not material;
12. Negotiate with the successful bidder within the scope of the RFP in the best interests of the state;
13. Conduct contract negotiations with the next responsible bidder, should the Department be unsuccessful in negotiating with the selected bidder;
14. Utilize any and all ideas submitted in the proposals received;
15. Every offer shall be firm and not revocable for a period of three hundred and sixty-five (365) days from the bid opening, to the extent not inconsistent with section 2-205 of the uniform commercial code. Subsequent to such three hundred and sixty-five (365) days, any offer is subject to withdrawal communicated in a writing signed by the offerer; and,
16. Require clarification at any time during the procurement process and/or require correction of arithmetic or other apparent errors for the purpose of assuring a full and complete understanding of an offerer's proposal and/or to determine an offerer's compliance with the requirements of the solicitation.

5.12 Freedom of Information Law ("FOIL")

All proposals may be disclosed or used by DOH to the extent permitted by law. DOH may disclose a proposal to any person for the purpose of assisting in evaluating the proposal or for any other lawful purpose. All proposals will become State agency records, which will be available to the public in accordance with the Freedom of Information Law. **Any portion of the proposal that a Bidder believes constitutes proprietary information entitled to confidential handling, as an exception to the Freedom of Information Law, must be clearly and specifically designated in the proposal as directed in Section 6.1 (D) of the RFP.** If DOH agrees with the proprietary claim, the designated portion of the proposal will be withheld from public disclosure. Blanket assertions of proprietary material will not be accepted, and failure to specifically designate proprietary material may be deemed a waiver of any right to confidential handling of such material.

5.13 Lobbying

Chapter 1 of the Laws of 2005, as amended by Chapter 596 of the Laws of 2005, made significant changes as it pertains to development of procurement contracts with governmental entities. The changes included:

- a) made the lobbying law applicable to attempts to influence procurement contracts once the procurement process has been commenced by a state agency, unified court system, state legislature, public authority, certain industrial development agencies and local benefit corporations;
- b) required the above mentioned governmental entities to record all contacts made by lobbyists and contractors about a governmental procurement so that the public knows who is contacting governmental entities about procurements;

- c) required governmental entities to designate persons who generally may be the only staff contacted relative to the governmental procurement by that entity in a restricted period;
- d) authorized the New York State Commission on Public Integrity, (now New York State Joint Commission on Public Ethics), to impose fines and penalties against persons/organizations engaging in impermissible contacts about a governmental procurement and provides for the debarment of repeat violators;
- e) directed the Office of General Services to disclose and maintain a list of non-responsible bidders pursuant to this new law and those who have been debarred and publish such list on its website;
- f) required the timely disclosure of accurate and complete information from offerers with respect to determinations of non-responsibility and debarment; (Bidders responding to this RFP should submit a completed and signed Attachment 1, "Prior Non-Responsibility Determination".)
- g) increased the monetary threshold which triggers a lobbyist's obligations under the Lobbying Act from \$2,000 to \$5,000; and
- h) established the Advisory Council on Procurement Lobbying.

Subsequently, Chapter 14 of the Laws of 2007 amended the Lobbying Act of the Legislative Law, particularly as it related to specific aspects of procurements as follows: (i) prohibiting lobbyists from entering into retainer agreements on the outcome of government grant making or other agreement involving public funding; and (ii) reporting lobbying efforts for grants, loans and other disbursements of public funds over \$15,000.

The most notable, however, was the increased penalties provided under Section 20 of Chapter 14 of the Laws of 2007, which replaced old penalty provisions and the addition of a suspension option for lobbyists engaged in repeated violations. Further amendments to the Lobbying Act were made in Chapter 4 of the Laws of 2010.

Questions regarding the registration and operation of the Lobbying Act should be directed to the New York State Joint Commission on Public Ethics.

5.14 State Finance Law Consultant Disclosure Provisions

In accordance with New York State Finance Law Section 163(4)(g), State agencies must require all contractors, including subcontractors, that provide consulting services for State purposes pursuant to a contract to submit an annual employment report for each such contract.

The successful bidder for procurements involving consultant services must complete a "State Consultant Services Form A, Contractor's Planned Employment From Contract Start Date through End of Contract Term" in order to be eligible for a contract.

The successful bidder must also agree to complete a "State Consultant Services Form B, Contractor's Annual Employment Report" for each state fiscal year included in the resulting contract. This report must be submitted annually to the Department of Health, the Office of the State Comptroller, and Department of Civil Service.

State Consultant Services Form A: Contractor's Planned Employment and Form B: Contractor's Annual Employment Report may be accessed electronically at: <http://www.osc.state.ny.us/agencies/forms/ac3271s.doc> and <http://www.osc.state.ny.us/agencies/forms/ac3272s.doc>.

5.15 Debriefing

Once an award has been made, bidders may request a debriefing of their proposal. Please note the debriefing will be limited only to the strengths and weaknesses of the bidder's proposal, and will not include any discussion of other proposals. Requests must be received no later than fifteen (15) calendar days from date of award or non-award announcement.

5.16 Protest Procedures

In the event unsuccessful bidders wish to protest the award resulting from this RFP, bidders should follow the protest procedures established by the Office of the State Comptroller (OSC). These procedures can be found in Chapter XI Section 17 of the Guide to Financial Operations (GFO). Available on-line at: <http://www.osc.state.ny.us/agencies/guide/MyWebHelp/>

5.17 Iran Divestment Act

By submitting a bid in response to this solicitation or by assuming the responsibility of a Contract awarded hereunder, Bidder/Contractor (or any assignee) certifies that it is not on the "Entities Determined To Be Non-Responsive Bidders/Offerers Pursuant to The New York State Iran Divestment Act of 2012" list ("Prohibited Entities List") posted on the OGS website (currently found at this address: <http://www.ogs.ny.gov/about/regs/docs/ListofEntities.pdf>) and further certifies that it will not utilize on such Contract any subcontractor that is identified on the Prohibited Entities List. Additionally, Bidder/Contractor is advised that should it seek to renew or extend a Contract awarded in response to the solicitation, it must provide the same certification at the time the Contract is renewed or extended.

During the term of the Contract, should DOH receive information that a person (as defined in State Finance Law §165-a) is in violation of the above-referenced certifications, DOH will review such information and offer the person an opportunity to respond. If the person fails to demonstrate that it has ceased its engagement in the investment activity which is in violation of the Act within 90 days after the determination of such violation, then DOH shall take such action as may be appropriate and provided for by law, rule, or contract, including, but not limited to, seeking compliance, recovering damages, or declaring the Contractor in default. DOH reserves the right to reject any bid, request for assignment, renewal or extension for an entity that appears on the Prohibited Entities List prior to the award, assignment, renewal or extension of a contract, and to pursue a responsibility review with respect to any entity that is awarded a contract and appears on the Prohibited Entities list after contract award.

5.18 Piggybacking

New York State Finance Law section 163(10)(e) (see also <http://www.ogs.ny.gov/purchase/snt/sflxi.asp>) allows the Commissioner of the NYS Office of General Services to consent to the use of this contract by other New York State Agencies, and other authorized purchasers, subject to conditions and the Contractor's consent.

5.19 Encouraging Use of New York Businesses in Contract Performance

Public procurements can drive and improve the State's economic engine through promotion of the use of New York businesses by its contractors. New York State businesses have a substantial presence in State contracts and strongly contribute to the economies of the state and the nation. In recognition of their economic activity and leadership in doing business in New York State, bidders/proposers for this contract for commodities, services or technology are strongly encouraged and expected to consider New York State businesses in the fulfillment of the requirements of the contract. Such partnering may be as subcontractors, suppliers, protégés or other supporting roles. All bidders should complete Attachment 6, Encouraging Use of New York Businesses in Contract Performance, to indicate their intent to use/not use New York Businesses in the performance of this contract.

5.20 Diversity Practices Questionnaire

Diversity practices are the efforts of contractors to include New York State-certified Minority and Women-owned Business Enterprises ("MWBEs") in their business practices. Diversity practices may include past, present, or future actions and policies, and include activities of contractors on contracts with private entities and governmental units other than the State of New York. Assessing the diversity practices of contractors enables contractors to engage in meaningful, capacity-building collaborations with MWBEs.

5.21 Participation Opportunities for NYS Certified Service-Disabled Veteran-Owned Businesses

Article 17-B of the New York State Executive Law provides for more meaningful participation in public procurement by certified Service-Disabled Veteran-Owned Businesses ("SDVOBs"), thereby further integrating

such businesses into New York State's economy. DOH recognizes the need to promote the employment of service-disabled veterans and to ensure that certified service-disabled veteran-owned businesses have opportunities for maximum feasible participation in the performance of DOH contracts.

In recognition of the service and sacrifices made by service-disabled veterans and in recognition of their economic activity in doing business in New York State, Bidders/Contractors are strongly encouraged and expected to consider SDVOBs in the fulfillment of the requirements of the Contract. Such participation may be as subcontractors or suppliers, as protégés, or in other partnering or supporting roles.

For purposes of this procurement, DOH conducted a comprehensive search and determined that the Contract does not offer sufficient opportunities to set specific goals for participation by SDVOBs as subcontractors, service providers, and suppliers to Contractor. Nevertheless, Bidder/Contractor is encouraged to make good faith efforts to promote and assist in the participation of SDVOBs on the Contract for the provision of services and materials. The directory of New York State Certified SDVOBs can be viewed at: <https://ogs.ny.gov/veterans/>

Bidders are encouraged to contact the Office of General Services' Division of Service-Disabled Veteran's Business Development at 518-474-2015 or VeteransDevelopment@ogs.ny.gov to discuss methods of maximizing participation by SDVOBs on the Contract.

5.22 Intellectual Property

Any work product created pursuant to this agreement and any subcontract shall become the sole and exclusive property of the New York State Department of Health, which shall have all rights of ownership and authorship in such work product.

5.23 Vendor Assurance of No Conflict of Interest or Detrimental Effect

All bidders responding to this solicitation should submit Attachment 4 to attest that their performance of the services outlined in this IFB does not create a conflict of interest and that the bidder will not act in any manner that is detrimental to any other State project on which they are rendering services.

5.23 Executive Order 177 Prohibiting Contracts with Entities that Support Discrimination

The New York State Human Rights Law, Article 15 of the Executive Law, prohibits discrimination and harassment based on age, race, creed, color, national origin, sex, pregnancy or pregnancy-related conditions, sexual orientation, gender identity, disability, marital status, familial status, domestic violence victim status, prior arrest or conviction record, military status or predisposing genetic characteristics. In accordance with Executive Order No. 177, the Offeror certifies that they do not have institutional policies or practices that fail to address those protected status under the Human Rights Law.

6.0 PROPOSAL CONTENT

The following includes the format and information to be provided by each Bidder. Bidders responding to this RFP must satisfy all requirements stated in this RFP. All Bidders are requested to submit complete Administrative and Technical Proposals, and are required to submit a complete Cost Proposal. A proposal that is incomplete in any material respect may be rejected.

To expedite review of the proposals, Bidders are requested to submit proposals in separate Administrative, Technical, and Cost packages inclusive of all materials as summarized in Attachment A, Proposal Documents. This separation of information will facilitate the review of the material requested. No information beyond that specifically requested is required, and Bidders are requested to keep their submissions to the shortest length consistent with making a complete presentation of qualifications. Evaluations of the Administrative, Technical, and Cost Proposals received in response to this RFP will be conducted separately. Bidders are therefore cautioned not to include any Cost Proposal information in the Technical Proposal documents.

DOH will not be responsible for expenses incurred in preparing and submitting the Administrative,

Technical, or Cost Proposals.

6.1 Administrative Proposal

The Administrative Proposal should contain all items listed below. A proposal that is incomplete in any material respect may be eliminated from consideration. The information requested should be provided in the prescribed format. Responses that do not follow the prescribed format may be eliminated from consideration. All responses to the RFP may be subject to verification for accuracy. Please provide the forms in the same order in which they are requested.

A. Bidder's Disclosure of Prior Non-Responsibility Determinations

Submit a completed and signed Attachment 1, "Prior Non-Responsibility Determination."

B. Freedom of Information Law – Proposal Redactions

Bidders must clearly and specifically identify any portion of the proposal that a Bidder believes constitutes proprietary information entitled to confidential handling as an exception to the Freedom of Information Law. See Section 5.12, (Freedom of Information Law)

C. Vendor Responsibility Questionnaire

Complete, certify, and file a New York State Vendor Responsibility Questionnaire. DOH recommends that vendors file the required Vendor Responsibility Questionnaire online via the New York State VendRep System. To enroll in and use the New York State VendRep System, see the VendRep System Instructions at <http://www.osc.state.ny.us/vendrep/index.htm> or go directly to the VendRep System online at <https://portal.osc.state.ny.us>.

Vendors must provide their New York State Vendor Identification Number when enrolling. To request assignment of a Vendor ID or for VendRep System assistance, contact the OSC Help Desk at 866-370-4672 or 518-408-4672 or by email at ciohelpdesk@osc.state.ny.us.

Vendors opting to complete and submit a paper questionnaire can obtain the appropriate questionnaire from the VendRep website, www.osc.state.ny.us/vendrep, or may contact the Office of the State Comptroller's Help Desk for a copy of the paper form. Bidder's should complete and submit the Vendor Responsibility Attestation, Attachment 3.

D. Vendors Assurance of No Conflict of Interest or Detrimental Effect

Submit Attachment 4, Vendor's Assurance of No Conflict of Interest or Detrimental Effect, which includes information regarding the Bidder, members, shareholders, parents, affiliates or subcontractors. Attachment 4 must be signed by an individual authorized to bind the Bidder contractually.

E. M/WBE Forms

Submit completed Form #1 and/or Form #2, Form #4 and Form #5 as directed in Attachment 5, "Guide to New York State DOH M/WBE RFP Required Forms."

F. Encouraging Use of New York Businesses in Contract Performance

Submit Attachment 6, "Encouraging Use of New York State Businesses" in Contract Performance to indicate which New York Businesses you will use in the performance of the contract.

G. Bidder's Certified Statements

Submit Attachment 7, "Bidder's Certified Statements", which includes information regarding the Bidder. Attachment A must be signed by an individual authorized to bind the Bidder contractually. Please indicate the

title or position that the signer holds with the Bidder. DOH reserves the right to reject a proposal that contains an incomplete or unsigned Attachment 7 or no Attachment 7.

H. References

Provide references using Attachment 9, (References) for three (3) clients that you performed program evaluations for. Provide firm names, addresses, contact names, telephone numbers, email addresses and a brief description of the evaluation you performed.

I. Diversity Practices Questionnaire

The Department has determined, pursuant to New York State Executive Law Article 15-A, that the assessment of the diversity practices of respondents of this procurement is practical, feasible, and appropriate. Accordingly, respondents to this procurement should include as part of their response to this procurement, Attachment 10 "Diversity Practices Questionnaire". Responses will be formally evaluated and scored.

J. Executive Order 177 Prohibiting Contracts with Entities that Support Discrimination

Submit Attachment 11 certifying that it does not have institutional policies or practices that fail to address the harassment and discrimination of individuals on the basis of their age, race, creed, color, national origin, sex, sexual orientation, gender identity, disability, marital status, military status, or other protected status under the Human Rights Law.

6.2 Technical Proposal

The purpose of the Technical Proposal is to demonstrate the qualifications, competence, and capacity of the Bidder to perform the services contained in this RFP. The Technical Proposal should demonstrate the qualifications of the Bidder and the staff to be assigned to provide services related to the services included in this RFP.

A Technical Proposal that is incomplete in any material respect may be eliminated from consideration. The following outlines the information requested to be provided by Bidders. The information requested should be provided in the prescribed format. Responses that do not follow the prescribed format may be eliminated from consideration. All responses to the RFP may be subject to verification for accuracy.

While additional data may be presented, the following should be included. Please provide the information in the same order in which it is requested. Your proposal should contain sufficient information to assure DOH of its accuracy. Failure to follow these instructions may result in disqualification.

Pricing information contained in the Cost Proposal cannot be included in the Technical Proposal documents.

A. Title Page

Submit a Title Page providing the RFP subject and number; the Bidder's name and address, the name, address, telephone number, and email address of the Bidder's contact person; and the date of the Proposal.

B. Table of Contents

The Table of Contents should clearly identify all material (by section and page number) included in the proposal.

C. Documentation of Bidder's Eligibility Responsive to Section 3.0 of RFP

Bidders must be able to meet all the requirements stated in Section 3.1 of the RFP. The Bidder must submit documentation that provides sufficient evidence of meeting the criterion. This documentation may be in any format needed to demonstrate how they meet the minimum qualifications to propose.

NYSDOH will accept proposals from organizations with the following types and levels of experience as a prime contractor.

- A minimum of three (3) years' experience conducting large-scale (at least one million lives), multi-year program evaluations, including completion of at least one such large-scale (at least one million lives), multi-year program evaluation;
- A minimum of three (3) years of experience performing statistical analyses using claims and encounter data;
 - A minimum of three (3) years of experience performing each of the following:
 - statewide or CMS designated Medicaid region comparisons,
 - longitudinal evaluations, and
 - collecting and analyzing qualitative and quantitative data.
- At the time of bid, the bidder and any proposed subcontractors must attest to not having any direct business relationship with any of the MMC plans, and any of the HARP, HIV SNP, and SDC pilot site agencies. The prime contractor and any subcontractors utilized must continue to refrain from any direct business relationship with the MMC plans, and HARP, HIV SNP, and SDC pilot site agencies for the duration of the contract. The Managed Care Organization Directory by Plan (which includes links to HARPs and HIV SNPs) can be found at: https://www.health.ny.gov/health_care/managed_care/plans/mcp_dir_by_plan.htm and SDC pilot site agencies are Community Access, Inc. in New York City and Independent Living, Inc. in Newburgh. If a bidder or any proposed subcontractors has a direct business relationship, the bidder may propose an operational and information firewall that would eliminate the likelihood of any conflict of interest. At the time of bid, if an operational and information firewall is proposed, the bidder and any proposed subcontractors must attest that the firewall will be established prior to commencement of work and will provide for an independent and unbiased evaluation without the influence of any MMC plans or any of the HARP, HIV SNP, and SDC pilot site agencies.

Experience acquired concurrently is considered acceptable.

Failure to meet these Minimum Qualifications will result in a proposal being found non-responsive and eliminated from consideration.

D. Technical Proposal Narrative

Bidders' should provide the following:

D1. Executive Summary

The Bidder's executive summary should provide a collective understanding of the contents of the proposal, briefly summarize the strengths of the Bidder; key features of the proposed approach to meet the scope of the RFP; and the major benefits offered by the proposal.

D2. Organizational Capacity

The Bidder should describe:

- a. its organizational resources for collection and analysis of quantitative data, including expertise, equipment, and software.
- b. its organizational resources for collection and analysis of survey and interview data, including expertise, equipment, and software.

D3. Experience

The Bidder should describe its prior experience, as follows:

a. Quantitative Data Analysis:

- 1. Analysis of Medicaid claims data and data from other large data systems, including the goals of such analyses, manner of data access and data extraction.

2. Statistical analysis related to Medicaid demonstrations or waivers, including the types of analyses and software used.

3. Experience in ensuring data quality and integrity of results.

b. Qualitative Data Analysis:

1. Qualitative data analysis, including the methodology employed and any software used.

c. Report Preparation:

1. Preparation of reports including results of both quantitative and qualitative analysis.

2. Summative reporting of findings of large scale program evaluations or research projects.

NOTE: Bidders should clearly indicate those areas where a proposed subcontractor is providing the experience.

D4. Proposed Approach – Evaluation

The Bidder should provide a plan to evaluate New York State's HARP and SDC Pilot programs that meets the prevailing standards of scientific and academic rigor, as appropriate and feasible to address the questions outlined in RFP Section 4.0, Scope of Work. The plan should address the following:

a. Evaluation questions, including research design and plans for statistical analysis.

b. Measures they are proposing to use for each research question/outcome of interest.

c. Data access, security, and collection techniques being proposed, including how they plan to adhere to all applicable New York State policies.

d. Anticipated challenges to the implementation of the evaluation and proposed strategies to mitigate those challenges.

e. A detailed timeline, by month, for evaluation activities, specifying the timeframe for planning (including obtaining Institutional Review Board [IRB] approval, as needed), timeframe for obtaining required data use agreements, start-up and data collection and analysis including due dates for deliverables.

f. Coordinating and incorporating all research and findings from this Scope of Work into professionally written reports that detail all pertinent information and findings.

g. Collaborating with all stakeholders and partners, including but not limited to CMS.

D5. Proposed Approach – Staffing

The Bidder should describe its staffing plan. The plan should provide:

a. The staffing and organizational structure proposed to meet the project activities and deliverables. The proposed staffing plan should describe how project staff will have appropriate training and experience in program evaluation, quantitative data collection and analysis using large and complex data systems, statistical programming and analysis, qualitative data analysis, data programming and software (to facilitate data access), project oversight/coordination, and report preparation. Include a description of the roles for each proposed staff person.

b. A job description for each position proposed, detailing the qualifications for the position. Include projected hours per week and estimated hours to be dedicated to each major task of this project. For the designated lead evaluator, include the level of training (e.g., doctoral, master's) and experience in public health, epidemiology, biostatistics, health services research, statistics, social sciences, or related field you propose that position would need.

c. Describe how internal management will be conducted for this project. Management oversight should be adequate to ensure integrity of products throughout the course of the contract period.

d. Written acknowledgment that, within 30 calendar days of notice of award, if selected, the Bidder will submit resumes of the staff proposed in its staffing plan for review and approval of the New York State Department of Health, and that, in the event that a staff member becomes unavailable during the contract period, the Contractor will submit resumes within ten (10) business days of notification of the staff unavailability to the New York State Department of Health for review and approval prior to engaging work from the replacement on this contract.

NOTE: Resumes are not required and will not be evaluated.

6.3 Cost Proposal

Submit a completed and signed **Attachment B – Cost Proposal**. The Cost Proposal shall comply with the format and content requirements as detailed in this document and in **Attachment B**. Failure to comply with the format and content requirements may result in disqualification.

The bid price is to cover the cost of furnishing all of the said services, including but not limited to travel, materials, equipment, overhead, profit and labor to the satisfaction of the Department of Health and the performance of all work set forth in said specifications.

7.0 PROPOSAL SUBMISSION

A proposal consists of three distinct parts: (1) the Administrative Proposal, (2) the Technical Proposal, and (3) the Cost Proposal. The table below outlines the requested format and volume for submission of each part. Proposals should be submitted in all formats as prescribed below.

	Electronic Submission	Paper Submission
Administrative Proposal	2 dedicated flash drives or CDs labeled “Administrative Proposal” containing a standard searchable PDF file with copy/read permissions only.	4 Originals 6 Copies
Technical Proposal	2 dedicated flash drives or CDs labeled “Technical Proposal” containing a standard searchable PDF file with copy/read permissions only.	4 Originals 6 Copies
Cost Proposal	2 dedicated flash drives or CDs labeled “Cost Proposal” containing standard searchable PDF file(s) with copy/read permissions only.	4 Originals 6 Copies

1. All hard copy proposal materials should be printed on 8.5” x 11” white paper (single-sided) and **be clearly page numbered on the bottom of each page with appropriate header and footer information**. A font size of eleven (11) points or larger should be used. The Technical Proposal materials should be presented separate from the sealed Cost Proposal. The sealed Cost Proposal should also be presented in separate three-ring binder(s);
2. Where signatures are required, the proposals designated as originals should have a handwritten signature and be signed in blue ink.
3. The NYSDOH discourages overly lengthy proposals. Therefore, marketing brochures, user manuals or other materials, beyond that sufficient to present a complete and effective proposal, are not desired. Elaborate artwork or expensive paper is not necessary or desired. In order for the NYSDOH to evaluate proposals fairly and completely, proposals should follow the format described in this RFP to provide all requested information. The Bidder should not repeat information in more than one section of the proposal. If information in one section of the proposal is relevant to a discussion in another section, the Bidder should make specific reference to the other section rather than repeating the information;

4. Audio and/or videotapes are not allowed. Any submitted audio or videotapes will be ignored by the evaluation team; and
5. In the event that a discrepancy is found between the electronic and hardcopy proposal, the original hardcopy will prevail.

The proposal must be received by the NYSDOH, no later than the Deadline for Submission of Proposals specified in Section 1.0, (Calendar of Events). Late bids will not be considered.

Proposals should be submitted in three (3) separate, clearly labeled packages: (1) Administrative Proposal, (2) Technical Proposal and (3) Cost Proposal, prepared in accordance with the requirements stated in this RFP. Mark the outside envelope of each proposal as "RFP# 20024, "Independent Evaluation of the New York State Health and Recovery Plans (HARP) Program and Self-Directed Care (SDC) Pilot Program" – (Administrative) (Technical) or (Cost) Proposal submitted by (Bidder's name)". The three (3) sealed proposals may be combined into one (1) mailing, if desired.

Proposals must be submitted, by U.S. Mail, by courier/delivery service (e.g., FedEx, UPS, etc.) or by hand as noted below, in a sealed package to:

Department of Health (RFP # 20024)
Attention: Jay Cooper, Director of Planning
New York State Department of Health
Office of Quality and Patient Safety
Room 2084, Corning Tower
Albany, New York 12237

NOTE: You should request a receipt containing the time and date received and the signature of the receiver for all hand-deliveries and ask that this information also be written on the package(s).

Submission of proposals in a manner other than as described in these instructions (e.g., fax, electronic transmission) will not be accepted.

7.1 No Bid Form

Bidders choosing not to bid are requested to complete the No-Bid form Attachment 2.

8.0 METHOD OF AWARD

8.1 General Information

DOH will evaluate each proposal based on the "Best Value" concept. This means that the proposal that best "optimizes quality, cost, and efficiency among responsive and responsible offerers" shall be selected for award (State Finance Law, Article 11, §163(1)(j)).

DOH at its sole discretion, will determine which proposal(s) best satisfies its requirements. DOH reserves all rights with respect to the award. All proposals deemed to be responsive to the requirements of this procurement will be evaluated and scored for technical qualities and cost. Proposals failing to meet the requirements of this document may be eliminated from consideration. The evaluation process will include separate technical and cost evaluations, and the result of each evaluation shall remain confidential until evaluations have been completed and a selection of the winning proposal is made.

The evaluation process will be conducted in a comprehensive and impartial manner, as set forth herein, by an Evaluation Committee. The Technical Proposal and compliance with other RFP requirements (other than the Cost Proposal) will be weighted **80%** of a proposal's total score and the information contained in the Cost Proposal will be weighted **20%** of a proposal's total score.

Bidders may be requested by DOH to clarify the contents of their proposals. Other than to provide such information as may be requested by DOH, no Bidder will be allowed to alter its proposal or add information after the Deadline for Submission of Proposals listed in Section 1.0 (Calendar of Events).

In the event of a tie, the determining factors for award, in descending order, will be:

- (1) lowest cost and
- (2) proposed percentage of MWBE participation.

8.2 Submission Review

DOH will examine all proposals that are received in a proper and timely manner to determine if they meet the proposal submission requirements, as described in Section 6.0 (Proposal Content) and Section 7.0 (Proposal Submission), including documentation requested for the Administrative Proposal, as stated in this RFP. Proposals that are materially deficient in meeting the submission requirements or have omitted material documents, in the sole opinion of DOH, may be rejected.

8.3 Technical Evaluation

The evaluation process will be conducted in a comprehensive and impartial manner. A Technical Evaluation Committee comprised of programmatic staff ~~of DOH~~ will review and evaluate all proposals.

Proposals will undergo a preliminary evaluation to verify Minimum Qualifications to Propose (Section 3.0).

The Technical Evaluation Committee members will independently score each Technical Proposal that meets the submission requirements of this RFP. The individual Committee Member scores will be averaged to calculate the Technical Score for each responsive Bidder.

The technical evaluation is **80% (up to 80 points)** of the final score.

8.4 Cost Evaluation

The Cost Evaluation Committee will examine the Cost Proposal documents. The Cost Proposals will be opened and reviewed for responsiveness to cost requirements. If a cost proposal is found to be non-responsive, that proposal may not receive a cost score and may be eliminated from consideration.

The Cost Proposals will be scored based on a maximum cost score of 20 points. The maximum cost score will be allocated to the proposal with the lowest all-inclusive not-to-exceed maximum price. All other responsive proposals will receive a proportionate score based on the relation of their Cost Proposal to the proposals offered at the lowest final cost, using this formula:

$$C = (A/B) * 20\%$$

A is Total price of lowest cost proposal;

B is Total price of cost proposal being scored; and

C is the Cost score.

The cost evaluation is **20% (up to 20 points)** of the final score.

8.5 Composite Score

A composite score will be calculated by the DOH by adding the Technical Proposal points and the Cost points awarded. Finalists will be determined based on composite scores.

8.6 Reference Checks

The Bidder should submit references using Attachment 9 (References). At the discretion of the Evaluation Committee, references may be checked at any point during the process to verify bidder qualifications to propose (Section 3.0).

8.7 Best and Final Offers

NYSDOH reserves the right to request best and final offers. In the event NYSDOH exercises this right, all bidders that submitted a proposal that are susceptible to award will be asked to provide a best and final offer. Bidders will be informed that should they choose not to submit a best and final offer, the offer submitted with their proposal will be construed as their best and final offer.

8.8 Award Recommendation

The Evaluation Committee will submit a recommendation for award to the Finalist(s) with the highest composite score(s) whose experience and qualifications have been verified.

The Department will notify the awarded Bidder(s) and Bidders not awarded. The awarded Bidder(s) will enter into a written Agreement substantially in accordance with the terms of Attachment 8, DOH Agreement, to provide the required services as specified in this RFP. The resultant contract shall not be binding until fully executed and approved by the New York State Office of the Attorney General and the Office of the State Comptroller.

ATTACHMENTS

The following attachments are included in this RFP and are available via hyperlink or can be found at: <https://www.health.ny.gov/funding/forms/>.

1. Bidder's Disclosure of Prior Non-Responsibility Determination
2. No-Bid Form
3. Vendor Responsibility Attestation
4. Vendor Assurance of No Conflict of Interest or Detrimental Effect
5. Guide to New York State DOH M/WBE Required Forms & Forms
6. Encouraging Use of New York Businesses in Contract Performance
7. Bidder's Certified Statements
8. DOH Agreement
9. References
10. Diversity Practices Questionnaire
11. Executive Order 177 Prohibiting Contracts with Entities that Support Discrimination

The following attachments are attached and included in this RFP:

- A. Proposal Document Checklist
- B. Cost Proposal
- C. HARP Targeting Criteria and Risk Factors
- D. Perception of Care Survey for Medicaid Managed Care Members
- E. BH HCBS Eligibility Brief Assessment Tool
- F. BH HCBS Full Assessment Tool

**ATTACHMENT A
PROPOSAL DOCUMENT CHECKLIST**

Please reference Section 7.0 for the appropriate format and quantities for each proposal submission.

RFP 20024– Independent Evaluation of the New York State (NYS) Health and Recovery Plans (HARP) Program and Self-Directed Care (SDC) Pilot Program		
FOR THE ADMINISTRATIVE PROPOSAL		
RFP §	SUBMISSION	INCLUDED
§ 6.1.A	Attachment 1 – Bidder’s Disclosure of Prior Non-Responsibility Determinations, completed and signed.	<input type="checkbox"/>
§ 6.1.B	Freedom of Information Law – Proposal Redactions (If Applicable)	<input type="checkbox"/>
§ 6.1.C	Attachment 3- Vendor Responsibility Attestation	<input type="checkbox"/>
§ 6.1.D	Attachment 4 - Vendor Assurance of No Conflict of Interest or Detrimental Effect	<input type="checkbox"/>
§ 6.1.E	M/WBE Participation Requirements:	<input type="checkbox"/>
	Attachment 5 Form 1	<input type="checkbox"/>
	Attachment 5 Form 2 (If Applicable)	<input type="checkbox"/>
	Attachment 5 Form 4	<input type="checkbox"/>
	Attachment 5 Form 5	<input type="checkbox"/>
§ 6.1.E	Attachment 6- Encouraging Use of New York Businesses	<input type="checkbox"/>
§ 6.1.G	Attachment 7 - Bidder’s Certified Statements, completed & signed.	<input type="checkbox"/>
§ 6.1.H	Attachment 9 – References	<input type="checkbox"/>
§ 6.1.J	Attachment 10 - Diversity Practices Questionnaire	<input type="checkbox"/>
§ 6.1.I	Attachment 11 - Executive Order 177 Prohibiting Contracts with Entities that Support Discrimination	<input type="checkbox"/>
FOR THE TECHNICAL PROPOSAL		
RFP §	SUBMISSION	INCLUDED
§ 6.2.A	Title Page	<input type="checkbox"/>
§ 6.2.B	Table of Contents	<input type="checkbox"/>
§ 6.2.C	Documentation of Bidder’s Eligibility (Requirement)	<input type="checkbox"/>
§ 6.2.D	Technical Proposal Narrative	<input type="checkbox"/>
FOR THE COST PROPOSAL REQUIREMENT		
RFP §	REQUIREMENT	INCLUDED
§ 6.3	Attachment B- Cost Proposal	<input type="checkbox"/>

**ATTACHMENT B
COST PROPOSAL
RFP #20024**

For the deliverables and milestones identified in the form below, Bidders should complete the column furthest to the right titled “Cost.” Bidders must not change the column titled “Deliverables,” nor can they change the existing milestones listed in the column titled “Milestones” below, but they can add additional milestones and associated cost, as applicable, to the form below to align with the proposed milestones in their Technical Proposal.

For each Deliverable Milestone listed below, place the “Quantity” (number of times you will complete this milestone) and the “Price Per” (the price you are bidding for each time you complete the milestone) in the column titled Cost, then complete the row titled “Milestone Total” (total cost for that Milestone) by multiplying the rows labeled “Quantity” by the “Price Per” for each Deliverable Milestone.

For each Deliverable a Grand Total should be completed, add each Milestone Total within each Deliverable.

Deliverable	Cost	
1 – Expanded Evaluation Plan - HARP		
Milestone 1 – Draft Plan	Number	
	Price Per	
	Total	
Milestone 2 – DOH-approved Revised Plan	Number	
	Price Per	
	Total	
Milestone 3 – CMS-approved Final Plan	Number	
	Price Per	
	Total	
Deliverable 1 Total		
2 – Expanded Evaluation Plan – SDC Pilot		
Milestone 1 – Draft Plan	Number	
	Price Per	
	Total	
Milestone 2 – DOH-approved Revised Plan	Number	
	Price Per	
	Total	
Milestone 3 – CMS-approved Final Plan	Number	
	Price Per	
	Total	
Deliverable 2 Total		
3 – Evaluation Report - HARP		
Milestone 1 – Draft Report	Number	
	Price Per	
	Total	
Milestone 2 – DOH-approved Revised Report	Number	
	Price Per	
	Total	
Milestone 3 – CMS-approved Final Report	Number	
	Price Per	
	Total	
Milestone 4 – Monthly Progress Reports	Number	
	Price Per	
	Total	
Deliverable 3 Total		

4 – Evaluation Report – SDC Pilot		
Milestone 1 – Draft Report	Number	
	Price Per	
	Total	
Milestone 2 – DOH-approved Revised Report	Number	
	Price Per	
	Total	
Milestone 3 – CMS-approved Final Report	Number	
	Price Per	
	Total	
Milestone 4 – Monthly Progress Reports	Number	
	Price Per	
	Total	
Deliverable 4 Total		
5 - HARP, Goal 1		
Milestone 1 – Preliminary Analyses	Number	
	Price Per	
	Total	
Milestone 2 – Final Analyses	Number	
	Price Per	
	Total	
Milestone 3 – Interpretation of Findings	Number	
	Price Per	
	Total	
Deliverable 5 Total		
6 - HARP, Goal 2		
Milestone 1 – Preliminary Analyses	Number	
	Price Per	
	Total	
Milestone 2 – Final Analyses	Number	
	Price Per	
	Total	
Milestone 3 – Interpretation of Findings	Number	
	Price Per	
	Total	
Deliverable 6 Total		
7 – HARP, Goal 3		
Milestone 1 – Preliminary Analyses	Number	
	Price Per	
	Total	
Milestone 2 – Final Analyses	Number	
	Price Per	
	Total	
Milestone 3 – Interpretation of Findings	Number	
	Price Per	
	Total	
Deliverable 7 Total		
8 – SDC Pilot, Goal 1		
Milestone 1 – Preliminary Analyses	Number	
	Price Per	
	Total	
Milestone 2 – Final Analyses	Number	
	Price Per	
	Total	

Milestone 3 – Interpretation of Findings	Number	
	Price Per	
	Total	
Deliverable 8 Total		
9 – SDC Pilot, Goal 2		
Milestone 1 – Preliminary Analyses	Number	
	Price Per	
	Total	
Milestone 2 – Final Analyses	Number	
	Price Per	
	Total	
Milestone 3 – Interpretation of Findings	Number	
	Price Per	
	Total	
Deliverable 9 Total		
10 – SDC Pilot, Goal 3		
Milestone 1 – Preliminary Analyses	Number	
	Price Per	
	Total	
Milestone 2 – Final Analyses	Number	
	Price Per	
	Total	
Milestone 3 – Interpretation of Findings	Number	
	Price Per	
	Total	
Deliverable 10 Total		

By signing this Cost Proposal Bid Sheet, bidder agrees that the prices above are binding for 365 days from the proposal due date.

Date: _____ Signature: _____

Print Name and Title: _____

ATTACHMENT C
HARP Targeting Criteria and Risk Factors²⁵

- A. **HARPs:** Adult Medicaid beneficiaries 21 and over who are eligible for mainstream Managed Care Organizations (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 New York State [NYS]); or
 - ii. Service system or service provider identification of individuals presenting with serious functional deficits as determined by:
 - 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.
- B. **HARP Target Criteria:** NYS has chosen to define HARP targeting criteria as:
- i. Medicaid enrolled individuals age 21 and over;
 - ii. Serious Mental Illness (SMI)/Substance Use Disorder (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 NYS Office for People with Developmental Disabilities (OPWDD) (i.e., participating in an OPWDD program).
- C. **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" mental health service in the year prior to enrollment.
 - ii. Non-SSI individuals with three (3) 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 (3) years prior to enrollment.
 - iv. SSI and non-SSI individuals with three (3) or more psychiatric inpatient admissions in the three (3) years prior to enrollment.
 - v. SSI and non-SSI individuals discharged from a NYS Office of Mental Health (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 (5) years prior to enrollment.
 - vii. SSI and non-SSI individuals discharged from correctional facilities with a history of inpatient or outpatient behavioral health (BH) treatment in the four (4) years prior to enrollment.
 - viii. Residents in OMH-funded housing for persons with SMI in any of the three (3) years prior to enrollment.
 - ix. Members with two (2) or more services in an inpatient/outpatient chemical dependence detoxification program within the year prior to enrollment.
 - x. Members with one (1) inpatient stay with a SUD primary diagnosis within the year prior to enrollment.
 - xi. Members with two (2) or more inpatient hospital admissions with SUD primary diagnosis or members with an inpatient hospital admission for an SUD-related medical diagnosis-related group and a secondary diagnosis of SUD within the year prior to enrollment.
 - xii. Members with two (2) 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).
- D. **Behavioral Health Home and Community Based Services (BH HCBS) 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 BH HCBS.
- i. **Need-based Criteria:** Individuals meeting one (1) of the Needs-Based Criteria identified below will be

²⁵ New York Request for Qualifications for Behavioral Health Benefit Administration: Managed Care Organizations and Health and Recovery Plans. March 21, 2014. <https://www.omh.ny.gov/omhweb/bho/final-rfq.pdf>

eligible for BH HCBS:

- 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 BH 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 BH 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 BH HCBS.
 - a. Once an individual is enrolled in the HARP, a Health Home (or other State-designated entity) will initiate an independent, person-centered planning process to determine a plan of care.
 - b. This will include the completion of an evaluation for BH HCBS eligibility.
 - c. This process will comply with federal conflict-free case management requirements.
- iii. Individuals determined eligible for the BH HCBS services based on the brief evaluation using the BH HCBS Eligibility Brief Assessment will receive a conflict-free functional assessment from an appropriately qualified individual.
 - a. The assessment determines eligibility for BH HCBS and is used to establish a written, person-centered, individualized plan of care.
 - b. Assessments are conducted using a BH HCBS Eligibility Assessment, a tool derived from the interRAI, a standardized clinical and functional assessment tool consistent with the State’s approved Balancing Incentive Payment Program.
- 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 or their designee.
- vi. Reassessment of the plan of care (including need for BH HCBS) must be done at least annually; when the individual’s circumstances or needs change significantly; or at the request of the individual. Plans may require more frequent reviews of plans of care to evaluate progress towards goals, determine if goals have been achieved or whether the plan of care requires revision.

ATTACHMENT D

Perception of Care Survey for Medicaid Managed Care Members

Please tell us about your experience with your Medicaid Managed Care plan, the care you receive(d) from providers, and your perception of your own health and well-being.

We're asking about the behavioral health services covered in your plan. Behavioral health means mental health and/or substance use disorder.

- We want to know about your experience with behavioral health services like counseling, rehabilitation, inpatient treatment, emergency/crisis services, or medicine for mental health or substance use conditions.

1. Our records show that you are now in [HEALTH PLAN NAME]. Is that right?
 Yes → Go to Question 3
 No → Go to Question 2

2. What is the name of your health plan? (please print)

PART I: YOUR BEHAVIORAL HEALTH SERVICES

3. Did you receive behavioral health services in the last 12 months? Yes No

4. In the last 12 months, did you receive any treatment, counseling, or medicine for:

- a. Emotional or mental illness? Yes No
- b. Alcohol use? Yes No
- c. Drug use? Yes No
- d. Tobacco use? Yes No

5. Are you currently receiving behavioral health services? No Yes

→ **If Yes, Go To Question 7**

6. Please select the ONE main reason why you are no longer receiving behavioral health services.

<input type="checkbox"/> a. I no longer needed treatment because the problem that led to treatment was addressed.
<input type="checkbox"/> b. Treatment was not working as well as expected, so I stopped treatment.
<input type="checkbox"/> c. Treatment was no longer possible due to problems with transportation.
<input type="checkbox"/> d. Treatment was no longer possible due to problems paying for treatment.
<input type="checkbox"/> e. Treatment was no longer possible due to problems with finding time for treatment.
<input type="checkbox"/> f. Other reason(s) (please explain):

If you have not received behavioral health services in the past 12 months, skip to Part 3.

PART 2: ACCESS and QUALITY OF CARE

The next questions are about all the behavioral health services you got in the last 12 months that were covered by your Medicaid Managed Care plan.

- Please consider those services when answering the questions below.
- Please do NOT comment here about services that are NOT covered by your healthcare plan (e.g., self-help groups).
- **If you have not received behavioral health services in the past 12 months, skip to Part 3.**

In the last 12 months...	Never	Sometimes	Usually	Always	Not Applicable
7. How often did the people you went to for counseling or treatment explain things in a way you could understand?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. How often did the people you went to for treatment treat you with respect and kindness?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. How often did you get services at <u>days/times that were convenient</u> to you?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10. How often did you get services <u>where</u> you needed them?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11. How often did you get the services you needed <u>as soon as</u> you wanted?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
12. How often did the people you went to for counseling or treatment <u>spend enough time</u> with you?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
13. How often did you <u>feel safe</u> when you were with the people you went to for counseling or treatment?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
14. How often did the people you went to for treatment <u>listen carefully</u> to you?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
15. How often were you <u>involved as much as you wanted</u> in your treatment?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
16. How often were the people you went to for treatment sensitive to your cultural background (race, religion, language, etc.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
17. How often did the people you went to for treatment tell you what medication side effects to watch for?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
18. How often were the accommodations (for example wheelchair accessibility) you need to obtain services available?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

19. In the last 12 months, how much were you helped by the counseling or treatment you got?
 Not at all Somewhat Very Much

The following questions are about services that you might receive through your healthcare plan. For each of the services listed below that you received in the past 12 months, please tell us how helpful the services were.

Services you might receive	If you received this service in the past 12 months, how helpful was the service?			
	Very Helpful	Somewhat Helpful	Not at All Helpful	I did not receive this service
20. A Health Home care manager who coordinates your medical, behavioral health, and social service needs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
21. Peer support services (support and help provided by people who have experienced mental illness and/or substance use disorder)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
22. Assistance with returning to school or a training program	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
23. Assistance with finding or maintaining a job	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
24. Assistance with transportation other than medical transportation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
25. Help with finding housing or better housing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
26. Help in pursuing friendships and personal interests	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
27. Help in figuring out my finances, including getting any benefits I may be entitled to	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
28. Family support and training	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
29. Crisis respite services; i.e., residential care for 7 days or less, during a behavioral health crisis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
30. Help with developing a crisis or relapse prevention plan	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

PART 3: HEALTH, WELLNESS, AND QUALITY OF LIFE

The next questions are about your health.

31. During the **past 4 weeks**, how much difficulty did you have doing your daily work, both at home and away from home, because of your physical health? (*Please select one*)
- None at all
 Very little
 Somewhat
 Quite a lot
 Could not do physical activities
32. Have you used tobacco (e.g., cigarettes, e-cigarettes, pipes, cigars, smokeless or chewed tobacco) in the past 12 months?
- Yes
 No
 Prefer not to answer

	Yes	No	Not Applicable
33. Have you experienced any difficulties as a result of your <u>tobacco</u> use in the last 12 months (e.g., health, social, legal, or financial problems)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
34. Have you experienced any difficulties as a result of your <u>alcohol</u> use in the last 12 months (e.g., personal/family conflict, job instability, legal problems, and/or injuries)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
35. Have you experienced any difficulties as a result of your <u>drug</u> use in the last 12 months (e.g., personal/family conflict, job instability, legal problems, and/or injuries)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

The next group of questions ask about how satisfied you feel, using a zero to 10 scale. Zero means you feel no satisfaction at all. 10 means you feel completely satisfied. The middle of the scale is 5, which means you are neither happy nor sad.

How satisfied are you with..... ?	0	1	2	3	4	5	6	7	8	9	10
36. the things you have? Like the money you have and the things you own?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
37. your health?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
38. what you are achieving in life?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
39. your personal relationships?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
40. how safe you feel?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
41. feeling part of your community?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
42. how things will be later on in your life?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Please tell us if you Strongly Agree, Agree, are Neutral, Disagree, or Strongly Disagree with each statement below.

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
43. I am aware of community supports available to me.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
44. My living situation feels like home to me.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
45. I have access to reliable transportation.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
46. I have trusted people I can turn to for help.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
47. I have at least one close relationship.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
48. I am involved in meaningful productive activities.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

PART 4: BACKGROUND INFORMATION

The following information is collected to help ensure that services meet the needs of all individuals. Please do not share your name. Please check the boxes and fill in the blanks as applicable.

49. What is your age? _____

50. What was sex were you assigned at birth, on your original birth certificate? Female Male Unknown

51. Current gender identity – How do you describe yourself? (check one) Female Male Transgender
 Do not identify as female, male, or transgender Prefer not to answer

52. How would you describe your sexual orientation? Heterosexual or Straight Homosexual, gay or lesbian
 Bisexual Other
 Not sure Prefer not to answer

53. In what language do you prefer to communicate with your health care providers?
 English Spanish Other (please specify) _____

54. In what language do you prefer to read things about your health care?
 English Spanish Other (please specify) _____

55. Are you of Hispanic/Latino Origin? Yes, Hispanic or Latino No, not Hispanic or Latino

56. What is your race? (Select all that apply)
 White American Indian/Alaska Native Asian
 Black/African American Native Hawaiian/Other Pacific Islander Other

57. What is your highest level of education completed?
 Less than High School High School diploma or GED Business or technical school
 Some college, no degree College degree or higher

58. Are you currently enrolled in school? Yes No

59. Are you currently enrolled in a job training program? Yes No

60. Have you been employed in the past 12 months? Yes, I am currently employed
 Yes, but I am not currently employed No

61. Please indicate whether the following things affect your ability to work or your decisions about working. Select all that apply to you.

a. Lack of good jobs	<input type="radio"/>
b. Concern about losing benefits (e.g., Medicaid, etc.)	<input type="radio"/>
c. Lack of transportation	<input type="radio"/>
d. Physical health condition	<input type="radio"/>
e. Mental health condition	<input type="radio"/>
f. Arrest history	<input type="radio"/>
g. Lack of job training / education	<input type="radio"/>
h. Medication side effects	<input type="radio"/>
i. Workplace attitudes about mental illness and/or substance use problems	<input type="radio"/>
j. Retired and no longer looking for work	<input type="radio"/>

62. Have you been arrested in the past 12 months? Yes No

63. Have you experienced any difficulties with your housing over the past 12 months (e.g., 3 or more moves, having no permanent address, being homeless, living in a shelter)? Yes No

THANK YOU FOR COMPLETING THE SURVEY

ATTACHMENT E

BH HCBS Eligibility Brief Assessment Tool

Please email QQPS.ASU@health.ny.gov for an electronic copy of this attachment.

ATTACHMENT F:
BH HCBS Full Assessment Tool

Please email QQPS.ASU@health.ny.gov for an electronic copy of this attachment.