
HMA

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Workbook for OCFS Provider Training

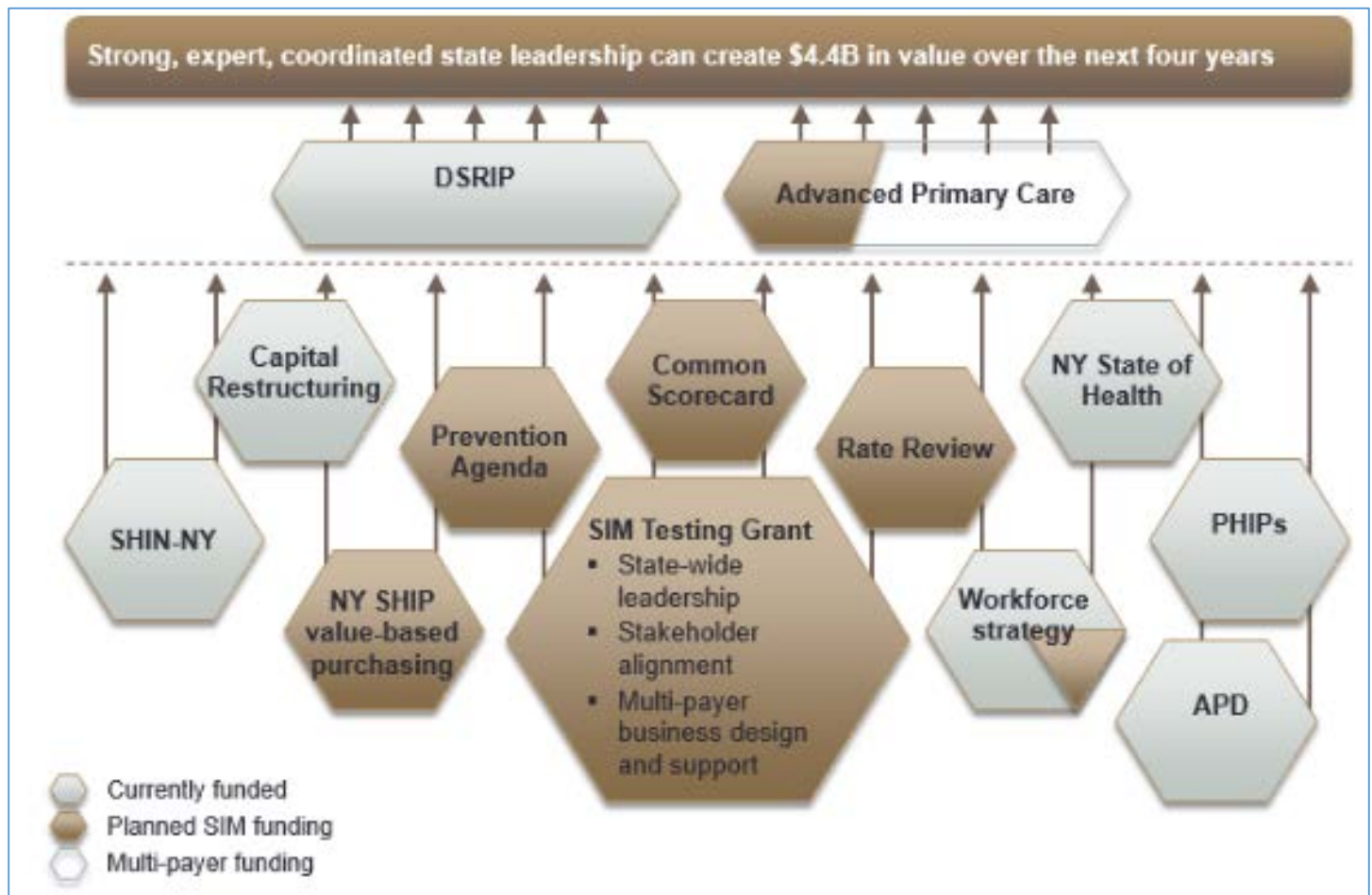
FOUNDATIONS IN ESSENTIAL
MEDICAID MANAGED CARE
BUSINESS AND OPERATIONS PRACTICES

THURSDAY, JULY 30TH, 2015
ALBANY

*Research and Consulting in the Fields of Health and Human Services Policy, Health Economics
and Finance, Program Evaluation, Data Analysis, and Health System Restructuring*

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Major Medicaid Transformation Initiatives Underway in New York State



Care Management for All

- 95% of the Medicaid population will be enrolled in Managed Care by 2018 (Currently about 80%)
 - Exceptions include:
 - Dual eligibles under 18
 - Hospice only recipients
 - Family planning only recipients
 - Emergency only recipients
 - Native Americans
 - Partial duals
- 4% or less of Medicaid spending will remain fee for service (FFS)

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State Innovation Model (SIM)

- \$99.9 million federal grant to NYS
- Goals
 - Statewide adoption of the Advanced Primary Care (APC) model
 - Shifting toward value-based payment
 - Supporting performance improvement and capacity expansion
 - Developing a common scorecard
 - Shared quality metrics and enhanced analytics to support the Triple Aim
 - HIT implementation, including enhanced capacities to exchange clinical data and an all-payer database

Delivery System Reform Incentive Payments (DSRIP)

- \$6.42 billion over five years
- Creates Performing Provider Systems (PPS)
 - Most headed by hospitals or hospital systems
- Reduce avoidable hospital admissions by 25%
- Reduce avoidable emergency room visits by 25%
- Moves the system toward population health management
- Strong push to integrate health and behavioral health care

Health Homes and Children's Health Homes

- An attempt to organize providers, Managed Care Organizations (MCOs) and Community Based Organizations (CBOs) into a coordinated, seamless system
- Consumers eligible for Health Homes
 - Have active Medicaid, and
 - Have two or more chronic conditions, or HIV/AIDS or Serious Mental Illness/Serious Emotional Disturbance, and
 - Are unlikely to be able to manage their own care effectively
- Considered an essential building block of the HARP and DSRIP initiatives

Balancing Incentive Payments (BIP)

- Financial incentives to shift from institutional long-term care to community-based long-term services and supports (LTSS)
 - Involves four state agencies (Health, Mental Health, Developmental Disabilities and Aging)
- \$599 million from 4/1/13 to 9/30/15 contingent on the ability of the State to increase the ratio of community-based care to institutional care
- Requires three structural changes
 - No wrong door/single point of entry system
 - Core standardized assessment instruments
 - Conflict free case management

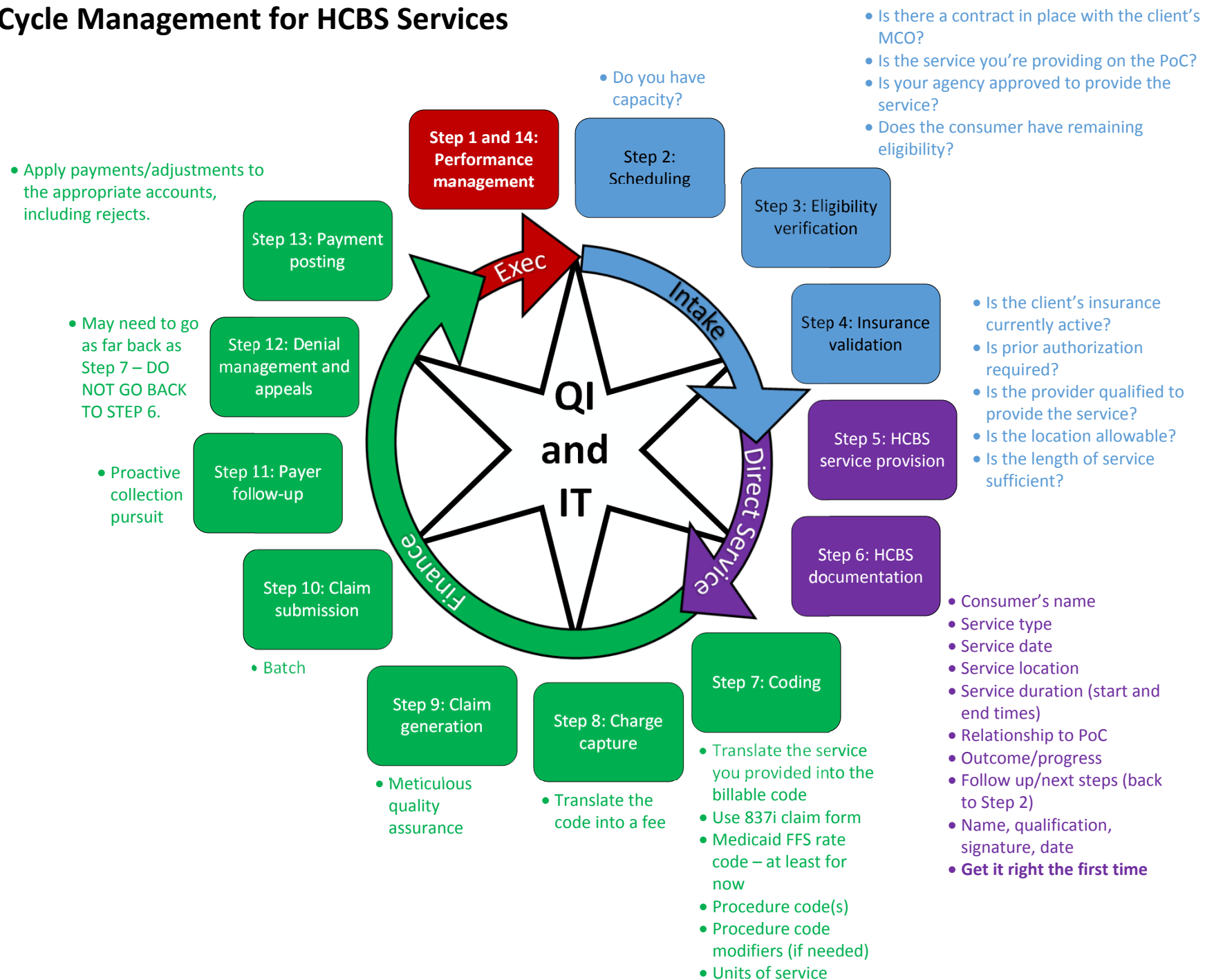
Fully Integrated Dual Advantage (FIDA) Capitated Demonstration

- Demonstration to run from July 2014 through December 2017
- Expected to cover 170,000 dual eligibles enrolled through Maximus
- Most of the 22 FIDA plans are Medicaid Managed Long Term Care plans (MLTCs) that expanded to include Medicare services
 - 139,000 participants were already enrolled in MLTCs
- Pilot in NYC and Nassau (Delayed in Suffolk and Westchester)
 - As of March 7th, 749 enrollees, 32,000 opt-outs

Money Follows the Person (MFP)

- Transitions eligible individuals from facilities into qualified community based settings
 - Focused on residents of nursing homes and Office for People with Developmental Disabilities (OPWDD)-funded facilities
- Two components
 - Peer outreach and referral
 - Transition centers

Revenue Cycle Management for HCBS Services



Information Transmission Needed for Revenue Cycle Management

Executive to Intake	Intake to Direct Service	Direct Service to Finance	Finance to Executive

Executive to Finance	Direct Service to Intake	Finance to Intake	Executive to Direct Service

Sample Minimal Medicaid Managed Care Infrastructure¹

		Cost
Personal Services		
	Billing Manager	
	Contracting/Credentialing Manager	
	Database Administrator	
	Data Analyst	
	Quality Improvement Director	
	Financial Analyst	
	Compliance Officer	
	Fringe	
Other than Personal Services		
	Billing System	
	EHR	
	Space/Equipment	
TOTAL		
Billing needed to support (@ 15%)		

¹ Note: This assumes a functioning extant agency infrastructure

Some types of collaborative models

Independent Practice Association (IPA)

Network of independent physicians or practices integrated clinically and/or financially

Provider Sponsored Organization (PSO)

Cooperative venture of a group of providers

Physician Practice Management Company (PPMC)

Purchases the tangible assets of the provider and provides all of the personnel and assets necessary to operate the agency in exchange for a management fee

Group Practice Without Walls (GPWW)

Created when a number of small organizations come together under a single tax ID

Management Services Organization (MSO)

Provides a range of non-clinical services to individual providers as a means of generating economies of scale and cost efficiencies. Some of the potential services offered by MSOs include:

- Administrative/ operational
- Financial
 - coding
 - billing
 - collections
- Personnel
- Education/training
- Data collection and management
- Quality management
- Utilization management
- Facilities management
- Equipment
- IT
- Marketing
- Compliance
- Credentialing
- Purchasing
- MCO negotiation and contracting
- Strategic planning assistance

Medicaid Managed Care (MMC)

Appeals and Grievances

Appeals 101

When a Medicaid managed care plan denies a service or claim (called an **adverse determination**), there are appeal rights. Appealing is how the provider or enrollee can get a decision overturned. Appeals rights and processes are in place for multiple types of denials, such as a denial of a service, of a claim payment, or of eligibility for HCBS. Providers have a right and a role to help their members with appeals and grievances. Documented provider support is often needed or helpful.

For plan denials (e.g., when a plan determines a service isn't covered), the plan will issue a **Notice of Action**. Appeal instructions are in this notice. There are deadlines and timeframes for appeal – it is important to adhere to these deadlines. There are also generally multiple levels of appeal, meaning that the appeal can be advanced to the next level if you are unsuccessful at first. Appeals can also be **expedited** if they are urgent.

There are standardized rules and timeframes that the appeals process must follow, regardless of the plan. Even when the enrollee is filing the appeal, having the support of their provider is important. There are **plan appeals** (submitted to the plan) and **external appeals** (submitted to an independent, external reviewer). External appeals are generally a next step if the plan denies your first appeal.

Grievances 101

Grievances and complaints are different from appeals. They can be filed with the plan or with the NYS Department of Health. They can be filed about any issue but they typically will not reverse a decision. It is best to file an appeal if you are seeking the reversal of a denial.

Appeals and Grievances Resources

- Medicaid Managed Care/Family Health Plus/HIV Special Needs Plan Model Contract: https://www.health.ny.gov/health_care/managed_care/docs/medicaid_managed_care_fhp_hiv-snp_model_contract.pdf
 - Section 10: Benefit Package Requirements
 - Appendix F: Action and Grievance System Requirements
 - Appendix K: Prepaid Benefit Package Definitions of Covered and Non-Covered Services
- New York State Department of Financial Services - <http://www.dfs.ny.gov/>
 - Provider rights: <http://www.dfs.ny.gov/insurance/hprovrght.htm>
 - Prompt Pay Law: <http://www.dfs.ny.gov/insurance/provlhow.htm>
- Behavioral Health Transition
http://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health_transition.htm

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Provider rights include:	
<ul style="list-style-type: none"> • Provider may discuss all treatment options with member even if service isn't covered by plan • Provider may assist enrollee with a grievance, appeal, or external appeal • Plans may not penalize or retaliate if a provider files a complaint with a government entity • Provider contract may not be terminated solely because provider advocated for enrollee; filed complaint; appealed plan decision; or asked for a hearing • Providers also have appeal rights on their own behalf 	
Member rights include:	
<p>Right to complain, grieve and appeal</p> <ul style="list-style-type: none"> • Notification of denials of treatment and grievance outcomes • Clinical rationale for the denial • Appeal of denials & timeframes for responding • External appeal <p>Right to information about plans</p> <ul style="list-style-type: none"> • Benefit description • Referral and authorization requirements • Provider network 	<p>Access to needed care</p> <ul style="list-style-type: none"> • Right to out-of-network care • Prudent layperson emergency care • Transitional care • Access to specialty care & specialty care centers <p>For MMC</p> <ul style="list-style-type: none"> • Expanded transitional care • Right to appeal any plan Action • Right to Fair Hearing and Aid Continuing • Reasonable assistance filing complaints and appeals

<p>How to Help Your Members Avoid Denials</p> <ul style="list-style-type: none"> • Verify Medicaid managed care eligibility prior to assessment or admission. • Know the provider contract and plan policies and procedures. • Obtain initial authorization, if needed, from the plan and provide services according to the approved care plan for the duration of the authorization. • Submit full information with request to support treatment level proposed in care plan, as indicated in plan procedures. • Learn from your denials. They are an opportunity for continuous quality improvement.
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Filing a Complaint with NYS Department of Health (DOH)

- Enrollees and providers can file a complaint with DOH regarding managed care plans
 - By phone (1-800-206-8125)
 - Or email (managedcarecomplaint@health.ny.gov)
- When filing:
 - Identify plan and enrollee
 - Provide all documents from/to plan
 - Medical record not necessary
- Issues that are not within DOH jurisdiction may be referred
- If you have a prompt pay complaint, this should be filed with the Department of Financial Services

Value Propositions

Ours

Define Target Customers:

HMA serves providers, payers and government throughout the United States in the publicly funded health and behavioral health service sector.

Define the Problem/Need

The Changing healthcare landscape requires extensive investment in strategic planning and problem solving by providers and payers to successfully remain relevant and thrive in the changing environment.

Your Unique Solution

HMA is comprised of former leaders and executives, high level individuals who designed and managed these systems.

What do you do better than anyone else?

High quality healthcare consulting on the changes occurring in the publicly funded healthcare system.

Yours

Define Target Customers:

Define the Problem/Need

Your Unique Solution

What do you do better than anyone else?

ABC SWOT Analysis

Strengths

- Reputation
- Deep relationship with the community
- Family and youth input in services
- Modest fund balance
- Great relationships with other foster care agencies
- Almost complete market share in the section of New York in which they are located
- Strong relationships with ACS and Juvenile Justice

Weaknesses

- Reliance on raised funds to balance the budget
- Very slim infrastructure that is not yet prepared for Medicaid Managed Care
- Minimal relationships with MCOs

Opportunities

- Chance to expand service portfolio via designation to provide additional HCBS services
- Chance to expand peer support, a service near to the heart of the agency
- Increase collaboration with FQHC
- Expansion of care management services with Health Home implementation

Threats

- Challenge of maintaining three separate billing constructs
 - State direct for foster care
 - PMPM to Health Homes
 - Medicaid Managed Care for HCBS services
- Uncertain funding and cash flow

Planning Template

30 Days

Agency Need	Milestone(s)	Responsible Party	Resources Needed
MCO Relations			
Contracting	Identify MCOs with which contracts will likely be needed		
Revenue Cycle Management			
QM/QI			
IT/EHR			
Demonstrating Value			
Strategic Planning	Conversation underway about how to adapt to the new service system	CEO	Board Engagement

60 Days

Agency Need	Milestone(s)	Responsible Party	Resources Needed
MCO Relations			
Contracting			
Revenue Cycle Management			
QM/QI			
IT/EHR			
Demonstrating Value			
Strategic Planning		CEO	Board Engagement

90 Days

Agency Need	Milestone(s)	Responsible Party	Resources Needed
MCO Relations			
Contracting			
Revenue Cycle Management			
QM/QI			
IT/EHR			
Demonstrating Value			
Strategic Planning		CEO	Board Engagement

By January 1, 2016

Agency Need	Milestone(s)	Responsible Party	Resources Needed
MCO Relations			
Contracting			
Revenue Cycle Management			
QM/QI			
IT/EHR			
Demonstrating Value			
Strategic Planning		CEO	Board Engagement

By January 1, 2018

Agency Need	Milestone(s)	Responsible Party	Resources Needed
MCO Relations			
Contracting	Contracts in place with all relevant MCOs		
Revenue Cycle Management			
QM/QI			
IT/EHR	Integrated EHR and billing system in place		
Demonstrating Value			
Strategic Planning		CEO	Board Engagement

10 Processes of Organizational Change

1. Consciousness Rating	Becoming more aware of a problem and potential solutions
2. Dramatic Relief	Emotional arousal (e.g. fear about failures, inspirations for successful change)
3. Self-Reevaluation	Appreciating that change is important to one's identity and success
4. Self-Liberation	Believing change can succeed and making a firm commitment
5. Environmental Reevaluation	Appreciating change will have a positive impact on the social and work environment
6. Reinforcement Management	Finding intrinsic and extrinsic rewards for new ways of working
7. Counter Conditioning	Substituting new behaviors and cognitions for the old ways of working
8. Helping Relationships	Seeking and using social support to facilitate change
9. Stimulus Control	Restructuring the environment to elicit new behaviors and inhibit old habits
10. Social Liberation	Empowering individuals by providing more choices and resources

Source: A Transtheoretical Approach to Changing Organizations. Prochaska J et al. Admin and Policy in Mental Health Vol 28 no 4, March 2001

Request for Qualifications (RFQ) for Medicaid Managed Care Organizations - Summary/Key Points -

1. Program Design

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

- **Qualified Mainstream MCOs:** For all adults served in mainstream MCOs throughout the State, the qualified MCO will integrate all Medicaid State Plan covered services for mental illness, substance use disorders (SUDs), and physical health (PH) conditions. Plans must meet the criteria contained in this RFQ to qualify to administer the BH benefit. Premiums for mainstream Plans will be adjusted to reflect the additional BH benefits of mainstream enrollees.
- **Health and Recovery Plans (HARPs):** HARPs are a distinctly qualified, specialized and integrated managed care product for adults meeting the serious mental illness (SMI) and SUD targeting criteria and risk factors. Within the HARPs, access to an enhanced benefit package will be offered in addition to all Medicaid behavioral health and physical health benefits. The enhanced array of home and community services are for HARP enrolled individuals who meet both targeting and risk factors, as well as needs-based criteria for functional limitations. The enhanced benefit package will help maintain participants in home and community based settings. The qualified HARP, contracting with Health Homes, will provide care coordination for all services including the 1915(i)-like Home and Community Based Services in compliance with home and community-based standards and assurances. New York State is working with Plans and Health Homes to develop clarity around care management roles and functions. The general expectation is that:
 - Health Homes will provide care coordination services, including comprehensive care management and the development of person centered plans of care; health promotion, comprehensive transitional care; patient and family support; and referral and connection to community and social support services, including to non-Medicaid Services.
 - Plans use data to identify individuals in need of high touch care management; identify patients disconnected from care, notify Health Homes when members show up in ERs and inpatient settings; and, monitor Health Home performance.

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

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- **Children in Mainstream MCOs:** Children's specialty BH services, including all four BH HCBS waivers operated by OMH and the Office of Children and Family Services, will be included in the mainstream MCOs at a later date. Plans will need to meet additional standards and contract requirements for the management of children's services at that time. The process for integrating children's BH services will be specified by New York State at a later date.
- **Integration of State Operated Psychiatric Services:** OMH is making several changes to the State operated psychiatric system as part of the creation of Regional Centers of Excellence (RCEs). The RCE plan includes the establishment of Regional Centers of Excellence across the State along with a network of state-operated community-based services that will respond to local needs. The restructuring of State operated psychiatric hospitals over several years will result in more than 600 fewer adult state psychiatric beds. As many of the individuals using these beds at admission or upon discharge will be enrolled in managed care, MCOs will be responsible for participating in discharge planning for their members and providing access to and overseeing aftercare services. This means that MCOs are not financially responsible for their enrollees who are admitted to or transferred to OMH psychiatric centers. OMH envisions a consumer-oriented model where Plans will be responsible for managing admissions and discharges from State hospitals, in addition to providing assistance in moving long stays out of State operated facilities. To begin this process, OMH is identifying historic and current admissions and lengths of stay at OMH inpatient facilities for adults enrolled in Medicaid Managed Care. As the RCE restructuring stabilizes, OMH and DOH will work with the MCOs to make the plans accountable financially and programmatically for continuing admissions/transfers of their members to the State facilities.

2. Purpose of the Request for Qualifications (RFQ)

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

However, Medicaid Managed Care Plans in NYS currently manage a limited range of behavioral health services. Many Plans do not have experience managing the complex behavioral health needs of the populations that will be coming into care management. Many of these individuals require a broader array of services to support functioning in the community, often over long periods of time.

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

Because Plans do not have the expertise to manage specialty BH benefits, they will need to:

- Hire in staff with appropriate expertise or
- Subcontract with a BH organization that meets the qualifications.

Plans are encouraged to develop a governance model that includes the experience of their expanded behavioral health network. However, these relationships cannot substitute for the Plan requirements included in this RFQ.

The purpose of this RFQ is to qualify:

- Current mainstream Medicaid MCOs in NYS to administer the full continuum of MH and SUD services covered under the Medicaid State Plan for adults who do not meet HARP eligibility criteria or who qualify but choose not to enroll.
- Current mainstream Medicaid MCOs seeking to become HARPs in NYS to administer the full continuum of MH, SUD, and PH services covered under the Medicaid State Plan as well as the enhanced Home and Community Based Service benefit package (1915(i)- like rehabilitation and recovery services) for adults with serious mental illness (SMI) and/or SUDs who meet HARP targeting and risk factors and/or 1915(i)-like functional eligibility criteria.

NYS will qualify MCOs and HARPs to serve adults in 2 rounds based on geographic region and population characteristics. The first round will be in New York City (NYC). The second round will be for the rest of the state. RFQ applications for Plans serving NYC are due by June 6, 2014. RFQ applications for Plans serving the rest of the state will be due six months later with the exact date to be determined. Additionally the RFQ for the rest of the state may be modified based upon experience obtained during the NYC qualification process. The process for integrating children's BH services into managed care will be specified by New York State at a later date.

Integration of all Medicaid BH and PH benefits under managed care will take place as follows:

Adults in New York City on January 1, 2016

Adults in the rest of the State on July 1, 2016

Children in New York City on January 1, 2017

Children in the rest of the State on January 1, 2017

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3. System Goals, Operating Principles, Requirements and Outcomes

Goals: The qualification process for MCOs and HARPs is necessary to ensure each has adequate capacity to assist NYS in achieving system reform goals including:

- Improved health outcomes and reduced health care costs through the use of managed care strategies and technologies including, but not limited to BH-specific protocols for:
 - Member services (intake, referral, crisis response)
 - Utilization management
 - Clinical management
 - Network management
 - Quality management
 - Data management
 - Reporting and financial management.
- Transformation of the BH system from an inpatient focused system to a recovery focused outpatient system of care.
- Improved access to a more comprehensive array of community-based services that are grounded in recovery principles including:
 - Person centered care management
 - Patient/consumer choice
 - Member and family member involvement at all system levels
 - Full community inclusion.
- Integration of physical and behavioral health services and care coordination through program innovations that address workforce development; risk screening; data integration and data analytics; and specialized case management and care coordination protocols.
- Effective innovation through the use of evidence-based practices.
- Improved cross system collaboration with State and local resources, including LGUs, State and locally funded MH and SUD services, housing subsidies and supports, the judicial system, welfare programs, and other local resources necessary to promote recovery outcomes.
- Delivery of culturally competent services.
- Assurance of adequate and comprehensive networks with timely access to appropriate services.
- Continuity of care during the transition from fee-for-service (FFS) to managed care.

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

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- a) Earlier identification and intervention through the use of validated screening tools where available for common conditions such as anxiety, depression, and alcohol misuse
- b) Person-centered treatment that integrates attention to behavioral and physical health care and to social needs within a framework that is strengths-based; culturally relevant; incorporates natural supports; and promotes hope, empowerment, mutual respect, and full community inclusion.
- c) Use of integrated care models such as the Collaborative Care model for treating BH conditions in primary care.
- d) An inclusive culturally competent provider network that contains a wide range of providers with expertise in treating and managing SMI and SUD consumers including community based providers of behavioral health and substance use services and peer delivered services.
- e) Efficient and timely service delivery, care coordination, and care management with minimal duplication across providers and between providers and the Plan.
- f) Access to care management and clinical management from a Health Home and/or MCO as appropriate.
- g) Enhanced discharge planning and follow-up care between provider visits.
- h) Reliance on specialized expertise for the assessment, treatment, and management of special populations, including older adults, transition age youth, individuals with co-occurring disorders (e.g. high risk medical populations), individuals experiencing a first episode psychosis (FEP), individuals with SMI and criminal justice or assisted outpatient treatment (AOT) involvement, and individuals with SMI and/or functionally limiting SUDs.
- i) Service delivery within a culturally competent comprehensive system of care, which emphasizes the most appropriate, least restrictive settings to promote and maintain the highest practical level of functioning.
- j) Medical necessity determinations that consider level of need as well as environmental factors, available resources and psychosocial rehabilitation standards.
- k) For behavioral health, Level of Care and clinical guidelines approved by the State.
- l) For SUD, Level of Care determinations based on the OASAS LOCADTR tool.
- m) Use of national data regarding evidence-based and promising practices as well as data from NYS regarding utilization and unmet needs to guide network enhancements and the allocation of resources to support individuals in achieving wellness and recovery.
- n) Use of data-driven approaches to performance measurement, management, and improvement with regular reporting of results on key performance indicators to stakeholders, e.g., consumers, providers, other member serving systems.
- o) Heightened monitoring of the quality of behavioral health and medical care for all members (those with mild and moderate conditions and those with high BH needs) with the use of ongoing outcome measurements intended to raise expectations for improvement in access, utilization, care coordination, health and recovery outcomes.
- p) Regular and ongoing technical support and training and workforce development with network BH and PH providers as well as managed care staff to achieve system transformation and to develop competency in current

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

- q) Use of financial structures that support and/or incentivize achieving system goals.
- r) Separate tracking of BH expenditures and administrative costs to ensure adequate funding to support access to appropriate BH services.
- s) Medical Loss Ratio (MLR) for HARPs and BH MLR for Mainstream MCOs.
- t) Reinvestment of behavioral health savings to improve services for behavioral health populations.
- u) Enhanced pharmacy management for individuals with co-occurring complex health, MH and SUD challenges.

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

- a) Improved individual health and behavioral health life outcomes
- b) Improved social/recovery outcomes including employment
- c) Improved member's experience of care
- d) Reduced rates of unnecessary or inappropriate emergency room use
- e) Reduced need for repeated hospitalization and re-hospitalization
- f) Reduction or elimination of duplicative health care services and associated costs
- g) Transformation to a more culturally competent community-based, recovery-oriented, person-centered service system.

4. Covered Populations and Eligibility Criteria

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

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

HARPs: Adult Medicaid beneficiaries 21 and over¹ who are eligible for mainstream MCOs are eligible for enrollment in the HARP if they meet either:

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

¹ One exception: individuals in nursing homes for long term care will not be eligible for enrollment in HARPs.

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- Service system or service provider identification of individuals presenting with serious functional deficits as determined by:
 - A case review of individual's usage history to determine if Target Criteria and Risk Factors are met; or
 - Completion of HARP eligibility screen.

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

- Medicaid enrolled individuals 21 and over
- SMI/SUD diagnoses
- Eligible to be enrolled in Mainstream MCOs
- Not Medicaid/Medicare enrolled ("duals")
- Not participating or enrolled in a program with the Office for People with Developmental Disabilities (OPWDD) (i.e., participating in an OPWDD program).

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

- Supplemental Security Income (SSI) individuals who received an "organized" MH service in the year prior to enrollment.
- Non-SSI individuals with three or more months of Assertive Community Treatment (ACT) or Targeted Case Management (TCM), Personalized Recovery Oriented Services (PROS) or prepaid mental health plan (PMHP) services in the year prior to enrollment.
- SSI and non-SSI individuals with more than 30 days of psychiatric inpatient services in the three years prior to enrollment.
- SSI and non-SSI individuals with 3 or more psychiatric inpatient admissions in the three years prior to enrollment.
- SSI and non-SSI individuals discharged from an OMH Psychiatric Center after an inpatient stay greater than 60 days in the year prior to enrollment.
- SSI and non-SSI individuals with a current or expired Assisted Outpatient Treatment (AOT) order in the five years prior to enrollment.
- SSI and non-SSI individuals discharged from correctional facilities with a history of inpatient or outpatient behavioral health treatment in the four years prior to enrollment.
- Residents in OMH funded housing for persons with serious mental illness in any of the three years prior to enrollment.
- Members with two or more services in an inpatient/outpatient chemical dependence detoxification program within the year prior to enrollment.
- Members with one inpatient stay with a SUD primary diagnosis within the year prior to enrollment.

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- Members with two 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.
- Members with two or more emergency department (ED) visits with primary substance use diagnosis or primary medical non-substance use that is related to a secondary substance use diagnosis within the year prior to enrollment.
- Individuals transitioning with a history of involvement in children's services (e.g., RTF, HCBS, B2H waiver, RSSY).

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

- **Need-based Criteria:** Individuals meeting one of the Needs-Based Criteria identified below will be eligible for 1915(i)-like services:
 - 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.
 - An individual with need for HCBS services as indicated by a face to face assessment with the interRAI Assessment Suite and a risk factor of a newly-emerged psychotic disorder suggestive of Schizophrenia herein called individuals with First Episode Psychosis (FEP). Individuals with FEP may have minimal service history.
 - A HARP enrolled individual who either previously met the needs-based criteria above or has one of the needs based historical risk factors identified above; AND who is assessed and found that, but for the provision of HCBS for stabilization and maintenance purposes, would decline to prior levels of need (i.e., subsequent medically necessary services and coordination of care for stabilization and maintenance is needed to prevent decline to previous needs-based functioning).
- All individuals in the HARP will be evaluated for eligibility for 1915(i)-like services.
 - Once an individual is enrolled in the HARP, a Health Home (or other qualified individual consistent with the provision of conflict free case management) will initiate an independent person-centered planning process to determine a plan of care.
 - This will include the completion of a brief evaluation for 1915(i)-like eligibility.
 - This process will comply with federal conflict-free case management requirements.
- Individuals determined eligible for the 1915(i)-like services based on the brief evaluation using the interRAI will receive a conflict-free functional assessment from an appropriately qualified individual,

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- The assessment determines the medical and psychosocial necessity and level of need for specific HCBS services; ensures that inappropriate, duplicative, or unnecessary services are not provided; and is used to establish a written, person centered, individualized plan of care.
- Individuals initially identified as HARP eligible **but not** currently enrolled in managed care will be referred to enrollment broker to help them decide which Plan is right for them.
- Once enrolled in the HARP, members will have 90 days to choose another HARP or return to a Mainstream MCO before they are locked into the HARP for 12 months from the date of enrollment (after which they are free to change Plans at any time).
- HARPs must notify members of their Health Home eligibility within a timeframe to be specified by the State.
- The Plans and Health Homes will operate under the terms of the Administrative Health Home Services Agreement and other policy and programmatic guidance that may be developed by NYS.
- Revised guidance regarding collaboration between Plans and Health Homes is being developed by the State with input from the Health Plan Associations.

5. Covered Services

- The MCO and HARP contracts for enrolled beneficiaries will cover all current physical health services and pharmacy benefits covered under mainstream managed care.
- The MCO and HARP contracts will cover Medicaid BH services including inpatient and outpatient hospital services and community-based rehabilitation and clinic services.
- HARP contracts will also cover the provision of 1915(i) Home and Community Based Services.
- In first two years of HARP operation, the HARP capitation payment will not include 1915(i) Home and Community Based Services. These will be paid on a non-risk basis with the HARP acting as an Administrative Services Organization (ASO).
- NYS will provide guidance for Plans and providers on 1915(i) Home and Community Based Services. Guidance will be distributed prior to implementation. Guidance will include:
 - Service definitions
 - Service components
 - Service limits
 - Admission/Eligibility Criteria

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- Settings (Location of Services)
- Provider Qualifications
- Billing procedure codes
- Service pricing
- NYS will develop a process for State designation of Home and Community Based Service providers.
- NYS anticipates that rehabilitation services for residents of community residences will be phased in to the capitation rate in year two.
- Concurrent with the Demonstration Amendment, NYS requested a State Plan Amendment (SPA) to move SUD clinic services to the rehabilitation option to provide services in a more recovery-oriented model and to add residential SUD services to ensure that Medicaid individuals have a full array of SUD services available to them.
- Cost-sharing will be unchanged from the current Medicaid FFS-approved State Plan. There is no nominal Medicaid cost-sharing approved in the State Plan for mental health or SUD services.
- The Plan will ensure that the member is offered all eligible benefits.
- Medicaid covered services will be available throughout the service area covered by the Plan and provided by the Plan's contracted providers, using the NYS Medicaid definition of "medically necessary services". As part of the RFQ review process, Plans will need to submit their proposed BH utilization review criteria to NYS for review and approval. All proposed utilization review criteria (including State Plan rehabilitation and 1915(i) waiver services) must be submitted no later than September 1, 2014.
- For all modalities of care, the duration of treatment will be determined by the member's needs and his or her response to treatment. All services, for which a member is eligible, will, at a minimum, cover:
 - The prevention, diagnosis, and treatment of health impairments;
 - The ability to achieve age-appropriate growth and development; and
 - The ability to attain, maintain, or regain functional capacity.
- During the term of the contract, the Plan may provide cost-effective alternative services ("in lieu of") that are in addition to those covered under the Medicaid State Plan as alternative treatment services and programs for enrolled members under 42 CFR 438.6(e).
 - The Plan must perform a cost-benefit analysis for any new services it proposes to provide, as directed by NYS, including how the proposed service would be cost-effective compared to the State Plan services.
 - The Plan can implement cost-effective alternative ("in-lieu of") services and programs only after approval by NYS.
 - The Plan is encouraged to assist NYS to develop cost-effective alternatives for services where it is beneficial to the recipient.
- MCOs may utilize telemedicine (including telepsychiatry) to the extent that it is medically appropriate and complies with all State and federal requirements.

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6. Rates

- All capitation payments are subject to actuarially soundness per 42 CFR 438.6(c).
- For individuals enrolled in mainstream MCOs, a distinct BH rate calculation will be applied for each existing premium group.
- For individuals enrolled in a HARP, NYS will establish an appropriate premium group and an integrated BH/PH capitation payment will be determined.
- The HARP capitation payment does not include 1915(i) services in first two years.
- For at least the first year of HARPs, the premium does not include Health Home payments.
- The HARP capitation payment does not include payment for rehabilitation services for residents of community residences.
- Historical eligibility, FFS claims and health plan encounter data were considered in developing appropriate base data for rate setting during the initial rating periods. As health plan experience emerges and is deemed to be sufficiently credible and reasonable, the base data for rate-setting will increasingly rely on actual health plan experience data.
- In order to develop capitation rates, the rate setting base data will be adjusted for factors including, but not limited to:
 - Program changes occurring between the beginning of the base data period and the end of the contract period.
 - Utilization and unit cost trend between the base period and the contract period.
 - Differences in expected costs associated with the transition from FFS to managed care and/or expectations around managed care efficiencies (as applicable).
 - Non-medical expenses, including costs associated with administrative functions, care management and underwriting gain.
- Final capitation rates will also be adjusted to account for any applicable withholds or risk sharing mechanisms that are a part of the program.
 - New York State will be replacing the current behavioral health stop-loss program for Medicaid Managed Care with a psychiatric (MH) inpatient specific stop-loss program. SUD detox and inpatient rehabilitation services will be included in the existing “acute care” inpatient stop loss program.

7. Performance Standards

- Plans must meet the qualifying criteria in this RFQ to manage the delivery of Medicaid behavioral health services. This may be done independently, or by subcontracting with a BH organization. Plans are encouraged to

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develop a governance model that includes the experience of their expanded behavioral health network. However, these relationships cannot substitute for the Plan requirements included in this RFQ.

- This document lists criteria that are in addition to present MCO requirements as delineated by the model contract. These existing requirements remain in place and must be met unless explicitly modified per this document.
- In the sections that follow, the requirements for all managed care plans are specified. Additional qualifying criteria must also be met to operate a HARP and administer the Home and Community Based Services benefits (1915(i)-like benefits). These include:
 - Covered services
 - NYS managed care rules
 - Approved BH UM criteria
 - Approved 1915(i) rules and requirements (for HARPs)
 - Provider networks
- 24 hour, 7 days a week, 365 days a year person staffed toll-free line to provide crisis referral.
- BH network development, care management, and provider relations activities. The Plan must demonstrate an adequate NYS presence of trained staff to ensure that BH network development, care management, and provider relations activities are sufficient to accomplish Plan Behavioral Health Goals.
- BH contracting, credentialing/re-credentialing. This function may be located out of state.
- BH provider relations with staff access to a claims reporting and payment reporting platform (claims may be administered at another location).
- BH utilization reviews with 24 hour, 7 days, 365 days a year a week access to appropriate personnel to conduct prior authorization. Per federal guidelines, the MCO must respond to prior authorization requests for post stabilization services within 1 hour (24 hours a day).¹⁹ This service may be provided out-of-state but Plan staff must demonstrate knowledge of:
 - Covered services
 - NYS managed care rules
 - Approved BH UM criteria
 - Approved 1915(i) rules and requirements (for HARPs)
- BH care management consistent with requirements at 42 CFR 438.208(c).
- BH clinical and medical management
- Education and training on topics required under this RFQ for medical and BH providers, State staff and other member serving agencies, except for specialized training where the Plan engages trainers with specialized expertise. Whenever possible, training and education for providers should be provided in coordination with the Regional Planning Consortiums (RPCs).
- BH resources to assist with BH-specific quality management (QM) initiatives, financial oversight, reporting and monitoring, and oversight of any subcontracted or delegated function.

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- The Plan must have an established technology platform that provides technology support to comply with requirements under this RFQ, including demonstrated success in:
 - Data exchange with any business associate that will perform activities required under the RFQ.
 - Provision of web-based portals with appropriate security features that allow BH providers and State agencies to submit and receive responses to BH referrals, requests for prior authorizations for BH services, and claims.
 - Data-driven approaches to monitor requirements described in the RFQ, by eligibility group when appropriate, including BH network adequacy, crisis plans, psychiatric advance directives, and BH-specific reporting requirements for UM, QM, and financial management as well as administrative and clinical performance metrics.

8. Experience Requirements

The Plan or its business associate must have more than five years of experience with Medicaid BH managed care programs. If a Plan is unable to demonstrate the experience required below, it can hire an adequate complement of experienced staff or contract with a Behavioral Health Organization. Plans choosing to hire experienced staff must submit the names, experience, and resumes of senior employees to be assigned to manage the BH benefit who have the required expertise including a minimum of five years of experience in the areas required below. Experience must include the following:

- Demonstrated success with the implementation of complex public sector BH (managed care or fee-for-service) programs in an efficient and effective manner. Plans will be expected to submit detailed information on the current management of their membership with BH needs, particularly those with complex conditions.
 - Plans will be expected to describe their experience managing care for other high need populations or complex benefits in NYS or elsewhere. For example:
 - Managed Long Term Care (MLTC)
 - HIV SNP
 - Homeless
 - Forensic BH
- Experience and demonstrated success with waiver services, peer supports, or community rehabilitation for disabled populations.
- Experience coordinating non-Medicaid funded care for Medicaid BH service recipients including coordination with local, State, and federal/other grant funded BH programs and supports (e.g., Substance Abuse Prevention and Treatment and Community Mental Health Services Block Grants).

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- Experience and demonstrated success in building and/or transforming a network delivery system to embrace principles of wellness and recovery, as demonstrated by:
 - The development of a qualified culturally competent provider network that emphasizes evidence-based and promising practices.
 - The incorporation of the preferences of members and their families in the design of services and supports (person-centered care planning).
 - The incorporation of a holistic approach in the design and delivery of services and supports, including assisting the member with obtaining and maintaining stable, safe, permanent housing; meaningful employment; social networks; and health and wellness.
 - Collaborating with consumer and/or family-run services, demonstrated by incorporating peer-run services into the provider network.
 - The use of self-management and relapse prevention skills, Wellness Recovery Action Plans (WRAPs), and psychiatric advance directives.
 - Operating a utilization and care management program for a comprehensive array of BH programs and services similar to those covered under the core benefit package described in this RFQ.
 - Success includes a demonstrated reduction of inappropriate admissions and readmissions to the emergency room, inpatient, or other 24-hour levels of care for psychiatric or addiction disorders.
 - Plans should describe their success in reducing behavioral health readmissions and increasing connectivity from inpatient to outpatient services (both BH and PH).
 - Plans should provide their current readmission rates for mental health inpatient and substance use rehabilitation and detox.
 - Plans should provide their current utilization of the BH clinic and inpatient benefits.
 - Experience in providing services to other Medicaid or government-sponsored Plans for members and populations similar to the covered members under this RFQ as demonstrated by:
 - Expertise managing the full range of services for individuals with primary or co-occurring SUDs, including experience managing methadone and buprenorphine and other addiction medications.
 - Expertise with the management and oversight of behavioral health pharmacy including polypharmacy, anti-psychotics, smoking cessation medications, and injectable antipsychotics.
 - Expertise managing BH care for special populations including, but not limited to adults with co-occurring I/DD and/or chronic medical conditions or transition-aged youth.
 - Experience and demonstrated success in implementing BH medical integration as evidenced by documented improvements in clinical and financial outcomes across the health care spectrum and communication/coordinated Plan of care development between medical and behavioral providers.

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

In addition to the above minimum organizational and experience requirements, Plans proposing to manage a HARP product line must meet the following requirements:

- The Plan or its staff shall have a proven track record in providing services to Medicaid or other government-sponsored Plans for members and populations similar to those described under the Home and Community Based Services 1915(i)-like component of the Demonstration Amendment as demonstrated by:
 - Experience and demonstrated success managing BH care for special populations including, but not limited to adults with SMI, adults with functionally limiting SUD, individuals experiencing a first episode psychosis, individuals with SMI and criminal justice involvement, adults residing in permanent supportive housing (PSH) or other types of community housing and homeless adults.
 - Experience and demonstrated success in operating a comprehensive care management program for HARP like populations.
- The Plan shall have a reasonable plan and sufficient internal resources with the relevant expertise or plan to hire an adequate complement of experienced staff to customize their technology platform to support compliance with federal HCBS requirements under the 1915(i)-like component of the 1115 waiver Demonstration Amendment. This includes evaluating the adequacy of plans of care compared to assessed needs and that services are delivered consistent with the plan of care.
- A reasonable plan and sufficient internal resources to review external functional assessments, service eligibility determinations, and plans of care for SMI and/or SUD populations.
- The Plan shall have a BH advisory subcommittee (for each region corresponding with RPCs) reporting to the MCO's governing board. The subcommittee will include peers, providers, local government and other key stakeholders.

Experience in managing mainstream BH benefits, MLTC, HIV SNP, Homeless, and Home and Community Based waiver services for non-SMI/SUD populations does not in and of itself demonstrate the ability to manage care for individuals with serious behavioral health disorders. Plans will be expected to provide details on how their experience qualifies them to manage BH benefits and networks in NYS, including HCBS benefits and network providers. Plans shall note the unique challenges to working with individuals with serious behavioral health conditions; local and system-wide barriers to effective care management; and their approach to addressing these challenges and barriers. Plans will be expected to describe how current processes and procedures will be augmented or changed to meet the needs of people with serious behavioral health conditions.

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Alternative Demonstration of Experience: As stated above, Plans that cannot demonstrate the required experience can: a) contract with a Behavioral Health Organization (BHO); or b) recruit new Plan BH leadership, managers and staff with experience that meet the requirements above.

9. Contract Personnel

The purpose of these staffing requirements is to ensure the Plans have required BH, PH, pharmacy, utilization management, quality management, and care management expertise to meet the needs of individuals with mental illness, addictions, and co-occurring physical health challenges. NYS expects that Plan staff will work as an integrated team with Health Homes, providers, and RPCs regardless of each Plan's organizational structure.

This section establishes minimum requirements for key personnel, managerial staff, and operational staff for the Mainstream MCO and HARP product lines, including requirements for staff to be dedicated to NYS Medicaid.

10. Network Service Requirements

The Plan's network service area shall consist of the county(ies) described in the Plan's current Medicaid managed care contract with NYS.

- Such service area is the specific geographic area within which eligible persons must reside to enroll in the MCO/HARP.
- For Plans applying to manage the behavioral health benefit in NYC (prior to the BH managed care state-wide roll out), the network service area consists of the city's five boroughs only.
- Plans must contract with BH providers outside the five boroughs (e.g., Nassau, Westchester) if the provider serves five or more of the Plan's members.

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

In establishing the network, the Plan must consider the following:

- Anticipated enrollment in Mainstream Plans and HARPs, and enrollment from other Plans;
- Expected utilization of services by the population to be enrolled;
- The number and types of providers (including new BH providers) necessary to furnish the services in the benefit package;
- The number of providers who are not accepting new patients;
- The geographic location of the providers and enrollees.

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- The language and mobility/accessibility of providers.

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

- Develop a BH network based on the anticipated needs of special populations, including:
 - Transition age youth with behavioral health needs
 - Adults and transition age youth identified with First Episode Psychosis
 - High risk groups such as individuals with SMI, co-occurring major mental disorders and SUDs and those involved in multiple services systems (education, justice, medical, welfare, and child welfare)
 - Individuals with I/DD in need of BH services
 - Individuals with a MH condition or a SUD and co-occurring chronic physical health condition
 - Individuals with a SUD in need of medication-assisted treatment, including methadone and buprenorphine for opioid dependence
 - Homeless individuals
 - Individuals in Supportive Housing or other types of community housing
 - Adults transitioning from State Operated Psychiatric facilities and other inpatient and residential settings
 - Individuals with SMI/SUD transitioning from jail/prison/courts
 - Individuals in AOT status.
- Maintain a network of physical health providers that:
 - Meets the physical health needs of people with SMI/SUD. The network of physical health providers is expected to be the same for the Mainstream MCO and the HARP;
 - Provides primary care screening for depression, anxiety, and SUD.

To be considered accessible, the network must contain a sufficient number and array of providers to meet the diverse needs of the member population. This includes:

- Being geographically accessible (meeting time/distance standards), culturally competent and being physically accessible for people with disabilities
- Providing BH services for members in their entire service area
- Ensuring a sufficient number of culturally competent providers in the network to assure accessibility to benefit package services provided by OMH or OASAS licensed programs and clinics and/or individual, appropriately licensed practitioners
- Ensuring sufficient physical health network capacity to meet the needs of people with SMI and/or SUD
- Sufficient primary care providers who provide screening for depression, anxiety disorders, and substance use with the capacity to treat or refer to appropriate specialty providers as necessary.

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Minimum network standards for each service type are shown in Table 3. Plans must meet the network requirements in Section 3.5. If contracting with required providers does not meet the minimum network standards, the Plan must contract with additional providers to meet the standard.

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