Behavioral Health RFQ Questions and Answers – May 2, 2014

Question #	Question	Answer
1	With expanding the BH/SUD benefits and adding the 1915(i) like services, can NYS provide direction regarding possible services that are duplicates?	Federal rules require that, with the exception of crisis services, the need for 1915(i) services must be identified in a person centered plan of care. The person centered plan is developed based on information obtained through a comprehensive assessment as well as other sources. The plan of care must identify the need for Medicaid state plan services, non-Medicaid services and any 1915(i) services. To the extent that a person's needs can be met through state plan services, the individual would not receive 1915(i) services.
2	Regarding quality of care monitoring, are provider self-audits an acceptable practice?	This question is too broad and more information is required to answer it properly. Plans should develop a comprehensive strategy for quality of care monitoring that is consistent with federal and state rules and regulations.
3	What is the anticipated timeframe for the completion of the HARPS satisfaction survey?	It is anticipated that a Consumer Assessment of Healthcare Providers and Systems satisfaction survey will be done for HARPs, as well as a HARP supplemental survey to assess perception of care. Both surveys are expected to be implemented in late 2015.
4	What are the qualifications needed to administer the Inter-RAI based tool	The qualification of the staff needed to administer the interRAI will be determined through a pilot being conducted over the summer.
5	Will physicians from the higher levels of care BH/SUD be able to recommend 1915(i) like services without utilizing the assessment?	No. The need for 1915(i) services must be identified in a person centered plan of care. Providers cannot just prescribe 1915(i) services.
6	What are the eligibility requirements for "transition age" youth to be included in the HARP population?	Transition age youth are individuals under age 23 transitioning into the adult system from any OMH, OASAS or OCFS licensed, certified, or funded children's program. This also includes individuals under age 23 transitioning from State Education 853 schools (These are operated by private agencies and provide day and/or residential programs for students with disabilities). To be eligible for the HARP, transition age youth must be 21 or over and meet the diagnostic or risk criteria outlined in the RFQ. Alternatively, transition age youth 21 and over may be determined eligible following

		completion of an eligibility screen.
7	How will rates reflect the costs for administering and managing BH HARP requirements?	HARP rates in NYC include 7.3% for administration and 1.5% for year 1 start-up costs. In NYC, this amounts to approximately $184.49 per member per month. This compares quite favorably to mainstream plans that only provide about $25 per member per month.
8	How will NYS modify provider expectations/requirements to align with plan expectations, e.g., integration of physical and behavioral health?	The integration of physical and behavioral health care is a key priority for New York State. NY is now developing an integrated license for providers and expects to issue these licenses throughout NYS in 2015. Over the next few years New York State (DOH, OMH and OASAS) will work with Plans to develop steps to achieve integration in primary care settings. The HARP will have an integrated premium and staffing requirements to reflect this priority. The RFQ also requires mainstream Plans to implement programs to manage complex and high-cost, co-occurring BH and medical conditions. Plans must also provide training for providers on integrated care. The RFQ has several integrated care requirements and specifically asks Plans to describe their experience with and/or planned approach to implementing BH-medical integration initiatives in section 4G.
9	Please clarify the definition of "health home care coordination" and the difference between the role of the health home role and the role of plan.	NYS continues to work with Plans and Health Homes to clarify the roles and responsibilities of Plans and Health Homes regarding care coordination. The general expectation is that Plans and Health Homes work as a team to improve the care that is delivered to Medicaid members: Health Homes 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 under a uniform set of standards to be developed.
10	What role is the plan expected to play in creating provider capacity to deliver new 1915(i) services if there are gaps?	NYS has committed to the initial development of 1915(i) services. For the first two years of implementation, 1915(i) Home and Community Based Services will be paid on a non-risk basis by the Plans. Plans will act as an Administrative Services Organization (ASO) for NYS with regard to these services. NYS will identify and designate 1915(i) providers, provide a services manual, and establish initial 1915(i) payment rates. Plans will be able to recommend additional 1915(i) providers, subject to review by NYS. Plans will need to contract with a sufficient network of 1915(i) providers to meet the needs of their members.
11	Please clarify "In lieu" services (see page 14). Are these services different from 1915i services?What is the approval process?	Federal rules require that, with the exception of crisis services, the need for 1915(i) services must be identified in a person centered plan of care. Access to these services is also capped by hours and total dollars. Once a 1915(i) service is in an approved plan of care, the individual is entitled to receive that service. In contrast, unless they are prevented by contract, a Plan may provide cost-effective alternative services ("in-lieu of") that are in addition to those covered under the Medicaid State Plan. These "in-lieu of" services

		are alternative treatment services and programs. "In-lieu of" services could be identical to 1915(i) services for individuals in Mainstream Plans where 1915(i) services are not available. A HARP may also chose to use "in-lieu of" services to pay for additional 1915(i) services beyond those allowable under the per person hour or dollar cap established by NYS. Dollars for "in-lieu of" services will be paid by the Plans from their premium and are not separately reimbursed by NYS.
12	Can plans limit the number of health homes to which they relate?	Plans may limit the number of health homes they contract with. However, consumers must be given choice if possible and HARPs will need sufficient Health Home capacity for their members. Plans will not be able to compel their members already enrolled in Health Homes to move to a "preferred" Health Home with which the Plan would like to care manage its members.
13	What type of entity will provide the conflict free assessment?	Subject to CMS approval for members enrolled in a Health Home, the assessment will be completed by the Health Home with appropriate firewalls approved by CMS. Individuals who are not enrolled in a Health Home will have the assessment administered by the enrollment broker. NYS will be providing additional guidance on this subject.
14	In item 3.1.A (page 24), a footnote indicates that a Plan merger creating a new plan will not disqualify the new plan from offering behavioral health benefits. We understand this to mean that if the legacy plan meets the timeframe requirements the new plan is eligible, even if the plan resulting from the	Yes this is correct.

	merger or acquisition has a new Medicaid number.	
15	3.1 Organizational Capacity: A. The Plan must be operating as a Medicaid MCO in NYS as of 3/1/13 and on the startup date. Can a Plan working with an experienced vendor, utilize the vendor's experience in Medicaid and/or as a Medicaid MCO to satisfy this requirement?	No. The Plan must have been operating as a Medicaid MCO in NYS as of 3/1/13 and on the startup date for this contract.
16	Who does the assessments to determine HARP eligibility? Also what data was used to design the policy?	In general, HARP eligibility is based on a combination of behavioral health diagnosis and behavioral health service history (both Medicaid reimbursed and other). These are explained on pages 16-18 of the RFQ. Additionally, other individuals eligible for Medicaid managed care may enroll in the HARP if they have a behavioral health diagnosis and serious functional deficits as identified through the completion of a HARP eligibility screen. These may be people with a first episode psychosis; people leaving jail or prison; people discharged from a State psychiatric hospital, or people identified by the Local Governmental Unit (LGU)
17	§ Behavioral Health Transition Grants. Are you able to provide any additional information on the State's plans for allocating the $20 million in behavioral health transition grant funding (e.g., number of recipients, award amounts, funding by type of entity, selection criteria)?	New York is working on a plan for the distributing this money and will share details in the near future.
18	§ Home Visits. Can you please confirm that home visits for behavioral health clinic	1915(i) community psychiatric support and treatment (CPST) also includes treatment in the community as part of goal directed supports and

	services will be covered under the community psychiatric support and treatment (CPST) 1915(i)-like service, addressing the current regulatory obstacles to coverage of home visits? How much funding do you anticipate being available to cover home visits?	solution-focused interventions intended to achieve identified goals or objectives as set forth in the individual's Treatment Plan. Pending CMS approval CPST services could be mobile but only for people who are determined 1915(i) eligible. There is no specific funding set-aside of funding for home visits.
19	§ *Crisis Services.* Could you please provide additional information on the options available to providers develop crisis/step-down beds and to convert existing residential beds into crisis beds? Plans report that providers are currently encountering regulatory obstacles as they attempt to do so. In addition, how much funding do you anticipate being available to cover crisis respite and intensive crisis support services through 1915(i)-like funding?	Some OMH licensed housing providers are requesting to convert some of their group home physical plant to crisis residences. The existing funding for the housing services would fund the same number of units in rental housing, freeing up the building. The providers will need a business plan to demonstrate that the crisis residence is sustainable from funding by health Plans. During the first two years, while the 1915i services are being billed FFS, we anticipate a limit of $5,000 per person in any 12 months unless the person changes plans. A Plan may provide more than $5,000 in crisis services, but they will have to pay for anything above $5,000 out of their capitation payments. After two, years, the exact amount of crisis services that will be built into the premium will be based on the 1915i billing history "trended" and annualized. It is unclear what regulatory barriers are being referred to, but both OMH and OASAS have the ability, under appropriate circumstances, to waive their regulations. The agencies will endeavor to work with the Plans to minimize regulatory obstacles to the implementation of the program.
20	Are 1915 Services excluded from the Mainstream Plans but included in the HARP?	1915(i) services are only available to individuals enrolled in the HARP and only if they are identified in their person centered plan of care.

		"In-lieu of" services could be identical to 1915(i) services for individuals in Mainstream Plans where 1915(i) services are not available. A HARP may also chose to use "in-lieu of" services to pay for additional 1915(i) services beyond those allowable under the per person hour or dollar cap established by NYS.
21	Members that go to Jail for extended periods 1+-6 Months, are they still enrolled in Managed Medicaid, BHO?	NYS is formulating a response and will post answers as soon as possible.
22	If Plan members are non-compliant with treatment and Health Home linkage, can they be restricted to fewer providers? To this end, is there a mechanism for disenrollment of members that are non-compliant?	HARP members who are not in a restricted recipient status may not be restricted to limited providers based on their refusal to comply with treatment or participate in a Health Home. Health Home enrollment is voluntary. At this point, Plans may not involuntarily disenroll members.
23	In the initial draft of the RFQ, I believe it stated that any "new" program to reduce costs would have to be approved by DOH prior to implementation, is that still the case? If so, this micro-management would hamper creative attempts to better manage this population.	NYS is balancing the need to safely transition the behavioral health system and service recipients into manage care with the need to transform the system to a more effective, community based and recovery oriented system. The RFQ establishes several transitional network requirements including the following: • Contracts for a minimum of 24 months with OMH or OASAS licensed or certified providers serving 5 or more members • Payment of FFS government rates to OMH or OASAS licensed or certified providers for ambulatory services for 24 months Plans and providers wishing to negotiate alternative payment methodologies for the first 24 months following implementation may do so pending State approval and subject to compliance with State and federal law. During the first two years of implementation, alternative payment arrangements must further the states' behavioral health transformation objective.

		Guidance from NYS will be issued at a later date.
24	As I contact MH residential providers regarding contracting with MCO's for commercial coverage for their residential programs two questions consistently arise. 1) Will SPOA play any role in placing Commercially insured members as the state does not fund their insurance? 2) Will OMH give guidance to these agencies that are reticent in contracting with the MCO's? If so when? Concern is that we are on a tight time frame 7/1/14 with offering this program, as per the Federal Government.	Rehabilitation supports in OMH community residences are not part of the capitation in year 1. OMH will be forming a work group to address the integration of residential supports in housing into managed care. OMH is currently reviewing the issue of access by commercially insured populations to OMH housing.
25	Is it possible to get the RFQ in Word Format?	NYS has released the RFQ in Word format on the DOH, OMH and OASAS websites.
26	If a health plan elects to qualify only as a mainstream MCO, will there be an opportunity at a later date to add a HARP program?	At this point, NYS is only qualifying HARPs through the current RFQ process. NYS may consider other qualifications in the future but no decision has been made at this time.
27	The definition of "delegated entity" (Section 2.0) limits the term to parent, subsidiary, affiliate and related organizations to which the plan will delegate certain responsibilities. Please confirm that the plan should limit its response to this subset of subcontractors with respect to questions in the RFQ that ask about	The requests pertaining to delegated entities throughout section 4.0 refer to any entity to which the plan will delegate provision of administrative and/or management services through a partnership, subcontract or other agreement, including those that are named specifically in the delegated entity definition in section 2.0.

	delegated entities. Please confirm if the State wants this information provided for outside vendors that are not related to the Plan's parent company (third party vendors)? See sections 4.0, 4.0.B.3.d, 4.0.G.2.e, 4.0.J.4	
28	Regarding Section 3.2, many plans have parent companies with plans operating in other states. Many functions are provided centrally on a shared services model. Because of the level of integration of the enterprise, we believe that the experience of the enterprise in providing services in other states is relevant to the services contemplated in the RFQ. Examples of questions where we think this experience applies include, but are not limited to, 4.0.A. 4, 4.0.A.5, 4.0.E.8, 4.0.E.10 and 4.0.E.16. Please confirm that plans can reference experience of this nature in their responses.	With regard to RFQ questions concerning Plan experience, Plans may refer to experience within the parent company unless the RFQ specifically states that experience must have been in NYS. However, where appropriate, the response should tie this experience back to the RFQ and address how the experience will be applied in NYS, and how knowledge about NYS needs, geography and service availability will be provided to out-of-state staff.
29	If a plan can document a good faith effort, but is unable to agree to a contract with a provider, will these good faith efforts satisfy the requirement that plans contract with the specified type and required number of providers in Section 3.6?	NYS expects that Plans make every effort to comply with the contracting requirements in Section 3.6. NYS recognizes that there may be some circumstances or areas of the State where the requirements in Section 3.6 cannot be completely met. If a Plan cannot meet all Section 3.6 requirements, NYS will review the reasons why on a case by case basis and work with the Plans to ensure that the intent of these requirements is met as effectively as possible. In the first 2 years government rates will be used, so price will not be an issue.
30	Question 4.0.A.3 requests certain information regarding subcontractors that provide "administrative or management services required under the RFQ." Please confirm this request is limited to those subcontractors who will be engaged specifically for the services	A HARP is a new line of business with additional responsibilities. NYS (DOH, OMH and OASAS) desire the opportunity to review the experience and performance of all entities (including subcontractors) supported with Medicaid funds.

	detailed in the RFQ. For example, a subcontractor providing peer review for behavioral health determinations would be included but an existing subcontractor providing 24-hour nurse-line would not be included.	
31	Questions 4.0A.4 and 4.0.A.5 ask the plan to identify years, customers and other information relating to its management of behavioral health, please confirm that the plan should include information on contracts in which it was required to manage behavioral health for its members but the plan subcontracted that function. We understand that the response should indicate that the behavioral health function was subcontracted in those situations.	If the management of BH for other contracts was subcontracted, the respondent should reflect this in its response. For any questions that pertain to a function that will be delegated, the response may and should reflect the experience or capability of the organization to which that function will be delegated. On any item where "the responder" includes a delegated entity, clearly identify the role of the Plan as distinct from the role of any delegate(s) and the name of the delegate(s) within the response.

32	Regarding the state's vision in Section 1.5.A.iv that would have health plans responsible for managing admissions and discharges from State hospitals, will the state be providing a transition plan that includes a timeline or proposed timeline for the shifting of admissions and discharge management to the plans?	NYS OMH psychiatric centers admit about 6,000 persons per year. A substantial minority are adults enrolled in Medicaid Managed Care. Most are transfers from Art 28 hospitals. Most are transferred long after the patient has had 30 psychiatric inpatient days. Most of these patients could be discharged from OMH with comprehensive "wrap around" housing, treatment and rehab services. OMH's objective is to outline how the Plans can and will reduce referrals. This objective is imbedded in the revised psychiatric inpatient Stop-Loss proposal currently being discussed with Plans. It is the expectation, that with more accountable ambulatory networks, higher quality care management, and improved discharge planning from inpatient settings, there will be fewer people referred to State psychiatric hospitals. NYS is also exploring other mechanisms to incentivize Plans to reduce the lengths of stay of their members who are admitted to OMH inpatient facilities.

33	Regarding Section 1.7.B.viii, how will the state insure appropriate involvement of the responsible MCO in the legal aspects of psychiatric care and will the state be providing guidance to the plans allowing them to manage members through the legal system. Will MCOs be responsible for patients admitted through the judicial system? If so how will the criteria be established and will it be a collaborative effort between the health plans, law enforcement, judiciary and the state?	The Plans will be responsible for the costs of court-ordered services in the benefit packages. The criteria for court-ordered admissions are statutory. Plans are urged to engage all parties, including relevant legal and judicial entities, in collaborative dialogue to effectively manage the services provided to their enrollees.
34	Regarding the reports that are requested in Question 1 of the Financial Management section of 4.0, does the State want only financially-focused reports, or is it sufficient to submit a variety of reports listed in section 3.16 and Attachment A?	The purpose of this question is to ascertain the experience and ability of the Plan to generate standard and ad-hoc reports as required by the RFQ. Plans may submit a mix of reports as listed in section 3.16 and Attachment A.
35	In section 4.0.E.1, the State requests that we describe our current Medicaid service area, including anticipated enrollment and utilization. Should we provide this information for all members, with behavioral health utilization broken out, or should we provide behavioral health utilization only?	This question is primarily, but not entirely, designed to ensure that Plans engage a sufficient number and diversity of providers in each county to meet the behavioral health needs of its members. Plans should provide the requested information for all services but with anticipated behavioral health utilization broken out by service type. Plans should identify the cultural/linguistic/demographic information that will influence their network development. Plans applying during the NYC qualification process should focus on only the 5 counties in NYC and any overlap into Westchester and Long Island as appropriate for NYC members.

36	Regarding training requirements in Section 4.0.E, relating to provider training, is there be an expectation that plans work jointly to provide universal training?	Whenever possible, training and education for providers should be provided in coordination with the Regional Planning Consortiums (RPCs). In NYC, this function will likely be managed by the NYC Department of Health and Mental Hygiene. RPCs will be created in a number of regions of the State to guide behavioral health policy in that region, problem solve regional service delivery challenges, and recommend provider training topics.
37	Regarding the experience requested in Section 4.0.E, question 8, is the State looking for specific experience in a specific contract with NYS, or can we pull relevant experience from another state served by one of our affiliate plans?	With regard to RFQ questions concerning Plan experience, Plans may refer to experience within other states unless the RFQ specifically states that experience must have been in NYS. For this question, the experience may be in other states. However, the question also asks Plans to relate this experience to your plan for BH in NYS.
38	Regarding Section 4.0.G, question 11, are plans expected to contract and coordinate with all AOT service providers similar to other provider types?	Assisted Outpatient Treatment (AOT) is court-ordered participation in outpatient services for certain people with serious mental illness who, in view of their treatment history and present circumstances, are unlikely to survive safely in the community without supervision. An AOT treatment plan may involve a variety of different services delivered by different providers. These providers may or may not be under a Plan contract. However, Plans must reimburse for these court-ordered services as per the terms of the model contract, provided that such ordered services are within the Plan's benefit package and Medicaid reimbursable. Additionally, plans are responsible for ensuring that the AOT plan of care is being met; that AOT reporting requirements are being met; and that people with an AOT court order are assigned to the proper level of care management.
39	Regarding Section 4.0.G, question 11, how will the Plan know that a member has received an AOT?	AOT plans are managed the Director of Community Services in each county. As required in Section3.3Q, Plans will need to have liaison staff to work with a number of member serving systems including counties.

		Plans will be provisioned with information on who has an active AOT order. Details on data provisioning and data sharing agreement requirements will be forthcoming.
40	Section 1.9.C says that the "State will provide rosters to MCOs of their Members whose service use histories indicate a need for HARP." Will the State be providing specific guidelines/requirements for MCOs to identify future HARP eligibles?	Individuals meeting targeting and risk factor criteria identified in Section 1.8 of the RFQ will be identified through quarterly Medicaid data reviews by NY State. NYS will then passively enroll identified individuals into their Plan's HARP if the Plan they are in offers a HARP. The State's enrollment broker will send a letter to these individuals explaining: 1. If they do not respond in 30 days, they remain in the HARP; 2. If they respond within 30 days and select a different HARP, the enrollment broker will enroll them in the selected HARP, or 3. If they respond within 30 days and choose to remain in the mainstream plan, the enrollment broker must enroll them back into mainstream Plan. If a Plan identifies a potential HARP member that is not identified through the State's data run, the State's enrollment broker (not the Plan) must determine HARP eligibility based on a HARP eligibility assessment.
41	Are State operated (OMH and OASAS) ambulatory services the only identified "essential community BH providers" at this time?	The State operated (OMH and OASAS) ambulatory services identified as "essential community BH providers in the RFQ are in addition to any essential community providers already required in the model contract. Additionally, Plans will be required to contract with all Opioid Treatment programs in their service area to ensure regional access and patient choice where possible.
42	Item G.1 states, "Please attach your proposed clinical management guidelines for all levels of BH care." And item F.1 states: "Attach the responder's proposed utilization review criteria for all levels of BH care."	Question F.1 asks plans to submit their UM/level of care guidelines. Question G.1 asks plans to tell us which guidelines they will adopt, disseminate, and implement to support specific evidence-based practices. Plans should tell us what guidelines they will use for the EBPs listed in 3.10.K.vi and add others they to propose to use.

	By clinical management guidelines, is the State referring to level-of-care utilization review criteria or another type of guideline?	
43	Regarding all questions in section E,F,G,H, and I: Would responders be allowed to exceed the page limit for specific questions if the total number of pages submitted for that section meets the section's total page limit?	No. Responders MUST stay within the page limits set in the RFQ.
44	If a member is receiving peer services in an OASAS clinic setting, does that preclude him or her from receiving peer services elsewhere? For example, there is a recovery peer in the OASAS clinic, but could there also be a peer who functions as a community health worker?	1915i Peer services are separate and distinct from other treatment services that may include a peer component.
45	If a HARP contracts with an IPA, can the plan delegate some of the provider training and oversight responsibilities to the IPA?	NYS is formulating a response and will post answers as soon as possible.
46	In the Network Management section (E), questions 2 (a) and (b) appear to duplicate question 7. Can you define any differences in expectations in regards to the response to these questions?	NYS is formulating a response and will post answers as soon as possible.
47	In discussions with some behavioral health providers, they have interpreted certain sections of the RFQ to mean that HIV SNPs could only manage the HARP benefit for people enrolled in the HIV SNP (not HIV negative populations). Is this the case -- that there will be "HIV SNP" HARPs? Or will an HIV SNP that achieves HARP designation be able to enroll HIV negative populations in its	At this time, an HIV/SNP approved to be a HARP would only be a HARP for its HIV members. NYS is considering options for non-HIV positive populations enrolled in an HIV/SNP.

	HARP?	
48	Regarding the NYS Request for Qualification Package (RFQ) to a become Health and Recovery Plans (HARP). Section L – Financial Management, Items 4b – 4d request that MCO applicants provide financial projections. Is there a specific template that should be completed? Alternatively, are there any specific guidelines to be considered regarding how the financial statements are organized?	NYS has developed a template and will be issuing it next week.

49	Regarding question 4.0.A.13, please confirm that this question is requesting information only about sanctions and other types of non-compliance notices that involve financial penalties. Audit findings, notices of non-compliance and similar written notices without financial penalties are standard elements of servicing government programs. If these non-financial items are required to be included in the response, would DOH, OMH and OASAS consider extending the page limit to ensure respondents can provide all of requested information?	NYS is formulating a response and will post answers as soon as possible.
50	Question L. 4 in section 4.0, states "Applicants must complete financial statements…" and Question L.5 states "Applicants must include the source of any additional capitalization that may be needed to support the new program…", items 4.b, c, and d, and 5 reference the "new program (HARP)". Please confirm if these are HARP only requirements. If these requirements are for both HARP and non-HARP plans, please confirm if you are looking for projected financial statements for L.4. If yes, please provide non-HARP rates to enable plans to create projections and identify any need/source of additional capitalization to	NYS is formulating a response and will post answers as soon as possible.

	support the new program.	
51	Will Health Home service plans be subject to approval by HARP MCOs? (Section 1.8/1.9)	Yes
52	Will all HARP members be offered the opportunity to enroll in a state-designated Health Home? (Section 1.8/1.9)	Yes
53	Will HARP plans be authorized to provide Health Home services? (Section 1.8/1.9)	No. However, the state is looking to allow Plans to develop an interim care management approach for HARP members until all HARP members are enrolled in Health Homes.
54	With HARP initiation on January 1, 2015 in NYC, what will the timeframe be for members currently unassigned to be enrolled in a Health Home? (Section 1.8/1.9)	NYS is working to enroll as many NYC HARP eligible members as possible prior to January 1. The expectation is that Plans will work to enroll members in Health Homes as rapidly as possible.
55	How will 1915i services be priced? (Section 1.11)	NYS will establish prices for 1915(i) services for the first two years and guidance will be issued.
56	What will the process be for authorizing providers to offer 1915i services? Will this require licensure or certification? (Section 1.9/3.6)	NYS will designate 1915(i) providers and licensure is not required.
57	What will the appeals process be for determinations regarding a HARP member's eligibility for 1915i like services and the approved scope/number of such services? (Section 1.8)	An appeal process for 1915i eligibility determination and 1915i service determinations will be implemented within the MCO's existing appeal process including a right to a fair hearing. The timeframes for an appeal will be consistent with the standard Medicaid contract.
58	What are the timeframes for 1915i service development? Is there a certain percentage of development funds that are required to flow to providers? (Section 1.10)	The plan for funding 1915(i) services will be shared as part of an overall guidance document being developed. HARPS will need to have an adequate network of 1915i services prior to beginning operations.
59	For plans that contract with a BHO, will all expenses for such a service be included as	The allowance in the calculation of the MLR and "risk corridor" for administration and "start up costs" includes the administrative expenditures of the HARP and the administrative costs of the BHO.

	medical loss or will a portion be considered administration? (Section 3.16)	
60	How will Health Home expenses be treated relative to medical loss allocation? (Section 3.16)	Health Home expenses are counted as medical loss for the purposes of arriving at a medical loss ratio. As HARPs commence, both State payments to the HARPs that are passed-through to Health Homes for care management and the State approved amount of the Health Home payment which is retained by the Plans (not to exceed 3.0%) are excluded from the calculations surrounding the MLR and "risk corridor".
61	What are the plans for a stakeholder advisory committee to offer input into the transition of behavioral care into managed care? (Section 3.12)	The MRT BH workgroup will continue to provide input on BH managed care implementation. Additionally, Regional Planning Consortiums will be created. These will provide an opportunity for stakeholder input.
62	Is there a process for plans to seek approval for "in lieu of" services? (Section 1.10)	No specific process is necessary. Plans may provide "in-lieu" of services unless such services are prohibited by the federal government or by their contract with the State.
63	How will plan utilization management criteria be made transparent to members? (Section 3.9)	Plans are required to describe their process for achieving this objective in their RFQ submission.
64	Will limits on opioid treatment services be allowed? (Section 1.10)	Opioid treatment should be managed based on medical necessity criteria with no mandatory limits applied. Long term opioid agonist and partial agonist treatment are evidence-based treatments for the management of opioid dependence.
65	What steps will NYS take to review and revise program regulations to insure consistency with managed care and encourage integrated services? (Section 1.10/3.5/3.6)	NYS will be creating a regulatory reform workgroup. Currently, NYS expects to begin this work in the fall of 2014.
66	Is it anticipated that some HARP eligible members will move out of HARP plans in the future and, if so, what will be the process and criteria for such a determination? (Section 1.8/1.9)	HARP members are free to change Plans according to the current managed care rules. At this time, there is no mechanism for involuntary disenrollment of HARP members.
67	How will the reinvestment of any behavioral	Behavioral Health Savings are the recoupments from the HARPs and

	savings be managed and made transparent to the public? (Section 3.16)	mainstream MCOs of any under expenditure of the minimum Medical Loss Ratio established in the State-Plan contracts. The under expenditures, if any, will not be determined until sometime after the close of each program year (which will be SFY) after review of each plan's submitted annual financial report. The State will publish the "savings" (and "losses") for each plan in each rate region as soon as they are known. The exact process for "reinvestment" will be developed in the first year of implementation and will include input from stakeholders.
68	Will members of HARP plans have access to the same medical and specialty networks as members of other service lines in the MCO? (Section 3.5)	Since HARPs are a line of business within existing Plans, NYS expects that HARP members have the same access to medical and specialty care as members in the mainstream Plan.
69	Will Medicaid FFS rates be applied to all outpatient services, not just clinic services? (Section 1.11)	Medicaid FFS rates will be applied to all OMH licensed and OASAS certified providers for 24 months.