NEW YORK STATE OF OPPORTUNITY. | Department of Health | Office of Mental Health | Office of Alcoholism and Substance Abuse Services

Complete Rest of State RFQ Questions

#	RFQ Section	Category	Question	Response
1.	N/A	General	Would the state please share the Q&A prepared for the downstate RFQ? Although some questions and answers maybe limited to NYC, there is likely information that would benefit all contained in it.	FAQs from the NYC applicants conference can be found online at: http://www.omh.ny.gov/omhweb/bho/faq.pdf Note: Answers to some of these questions have changed. NYS is in the process of reviewing these FAQs and will update as appropriate in the near future.
2.	N/A	General	Does contacting the RFQ contact if we wish to participate in the applicant's conference by teleconference constitute a breach of the blackout period?	All communications with the contract manager does not constitute a breach of the black-out period. Plans are encouraged to attend in-person however teleconference capabilities will be arranged
3.	Section 1.5.A.ii.	Health Home	If the member refuses a Health Home, is the HARP allowed to provide Case Management? If so, how is that to be funded?	If a person refuses Health Home enrollment, the HARP would contract with a health home (or other state designated entity) to complete the assessment and develop the HCBS plan of care. The Health Home would bill the HARP for these two services the rates established by the State. Once the HCBS plan of care has been developed, the Health Home Care Manager forwards the plan of care to the HARP and the HARP is responsible for monitoring and implementing the plan of care. The HARP would not be paid an additional fee for monitoring and implementing plans of care for their members who choose not to enroll in Health Homes.

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4.	Section 1.5.A.ii.b.	Reporting	What are the metrics that must be measured for HCBS and Health Home providers, or is it up to the HARPs and MCOs to determine the performance metrics per their contracts with those Health Homes and HCBS providers?	For HCBS - The Federal assurance and sub assurance requirements are being finalized. Additional information will be forthcoming.
5.	Section 1.7.C	Reporting	Are there standard reporting requirements/monitoring mechanisms or processes we are expected to use? Also, are these general outcomes or specific to HARP members/MMC members who access BH services?	Plans will continue to be responsible for reporting requirements in QARR. NYS will issue additional guidance regarding required transitional monitoring reports to NYS.
6.	Section 1.8.E.vi: Covered Populations and Eligibility Criteria	Clinical Management	Please clarify as to what entails a significant change in an individual's circumstances or needs.	Significant change is when an individual experiences an acute episode, is re-hospitalized or experiences an event where additional support is required to live safely in the community.
7.	Section 1.10.E: Covered Services	HCBS	What are the authorization requirements related to HCBS?	NYS is working in collaboration with the Health Plan Association to develop a uniformed UM policy for HCBS and Plan of Care.
8.	Section 3.1.I: Organizational Capacity	Member Services	Is the plan required to comply with 8am-6pm hours of operation for core business operations if this varies from existing plan hours?	Plans must comply with all standards reflected in the RFQ.

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9.	Section 3.2.A.iv.b.: Experience Requirements	Training	Please clarify the Plan's responsibility to deliver cultural competency training directly to provider staff vs. establishing a monitoring mechanism to ensure providers comply with this requirement.	This RFQ requires Plans to develop and implement a comprehensive provider training and support program that includes a cultural competence component. The State expects that Plans monitor compliance with these training requirements. Whenever possible, training and education for providers should be provided in coordination with the Regional Planning Consortiums (RPCs).
10.	Section 3.3.L.vi: Contract Personnel	Staffing	As a small HARP (under 4k members), a plan would be allowed to share key staff across products (e.g., MMC and HARP). If a plan with a small HARP delegates services to a BHO, can key BHO staff (e.g., CMO, Med Director) serve more than one plan within the BHO's book of business?	Yes, this is correct.
11.	Section 3.9.E.ii: Utilization Management	Utilization Management	What are the authorization requirements related to LOCADTR services?	LOCADTR is for initial and ongoing level of care determinations tool for all OASAS certified program types. "LOCADTR" is a patient placement criteria system designed to assure that a client in need of substance use disorder services is placed in the least restrictive, but most clinically appropriate level of care available that is to be used in making all initial and ongoing level of care decisions in New York State. LOCADTR is developed and updated, as appropriate, by the New York State Office of Alcoholism and Substance Abuse Services (OASAS), and is the clinical level of care tool that assesses the intensity and need of services for an individual with a Substance Use Disorder (SUD). The Contractor shall ensure that its' Participating Providers and/or Contractor's utilization management staff use the LOCADTR 3 assessment tool to make initial and ongoing level of care determinations for Substance

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				Use Disorder Services. Please note that while OASAS encourages plans to identify individual or program service patterns that fall outside of expected clinical practice OASAS does not permit plans to request / require from providers regular treatment plan updates for otherwise routine outpatient and opioid service utilization.
12.	Section 3.10(G)(i) and (ii): Clinical Management	General	What is the State's expectation as it relates to the plan developing definitive strategies to promote BH/medical integration that include co-location of BH practitioners in primary Care and Primary care into BH locations. Most PPSs formed, as a result of the availability of DSRIP funding, will be leading the efforts in this area, bolstered by the commitment of DSRIP funding to finance the effort and the state's support for regulatory relief. Short of lending guidance/input and support for the PPSs, it's not clear what the state's assumption is for a plan role in this integration.	Plans should describe new processes and procedures that they can implement that promote BH/Medical integration given the multiple statewide initiatives and resources available in health homes, DRSIP, etc.
13.	Section 4.0: Intro	General	For the hardcopy RFQ response, please confirm that the State requires 4 complete copies of the response. In addition, please clarify whether the electronic submission (PDF and Word) should include attachments or just the narrative response to Section A through K.	RFQ responses requires 4 complete responses and the PDF/Word versions should include attachments where possible.
14.	Section 4.0.A.5: Organization, Experience and Performance	Organization and Experience	Please clarify that this question is only for a BHO responding on behalf of a health plan. We otherwise assume that a plan's own experience in managing the BH population and benefits will be answered in A(4).	If the Plan is contracting with a BHO to meet the experience requirements both the Plan and the relevant delegate would need to respond both questions A.4 and A.5.

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15.	Section 4.0.A.5: Organization, Experience and Performance	General	Does the page limit apply to each government/public sector customer that the Plan/delegate has (i.e., one page per customer), or will the Plan/delegate need to list all of its government/public sector customers on one page.	Plans/delegate must submit 1 page per each government/public sector customer.
16.	Section 4.0.A.7: Organization, Experience and Performance	Organization and Experience	Please clarify whether this question applies only to BHO applicants or whether plans proposing to manage without BHO assistance should nonetheless provide details about their current key staff.	The RFQ allows the Plan to meet experience requirements by either, contracting with a BHO or using experience of key and managerial BH staff. This question pertains to Plans using experience of key and managerial staff.
17.	Section 4.0.A.12: Organization, Experience and Performance	Finance	Please clarify whether this question applies only to a BHO. If it applies to an MCO applying without BHO assistance, has DOH provided the current rate components that comprise the BH portions of a plan's rate? It's not currently clear in a plan's rate sheets what proportion of its revenue is for the BH service continuum.	This question applies to the MCOs and HARPs. This question only applies to what the Plan has paid for in calendar year 2013 and 2014.
18.	Section 4.0.B.4: Personnel	Staffing	Please clarify whether it is acceptable for including total FTE counts in some service areas of a plan if all FTEs in the service area will be trained and otherwise be available for carve-in or HARP services. For example, an MCO may not designate certain claims personnel for processing only Medicaid claims. All claims personnel are cross trained and any one person could work on a mainstream or HARP claim in his/her work queue. This could also be the case in appeals. All appeals staff are trained for all lines of business.	Any staff working on the product line should be trained and reflected in the HARP and Mainstream Personnel Requirements Table. The HARP and Mainstream Personnel Requirements Table identifies the percentage of time that the staff will work on the Mainstream and HARP.

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<tr><th>#</th><th>RFQ Section</th><th>Category</th><th>Question</th><th>Response</th></tr>
<tr><td>19.</td><td>Section 4.0.B.9: Personnel</td><td>Training</td><td>Are completed training materials required to be submitted with the RFQ response, or will the training plan be sufficient?

Some materials are still in process and will not be completed until DOH releases further guidance to upstate plans.</td><td>A training plan is sufficient as long as it addresses the criteria in Question B.9. Specific training materials will be reviewed during the Readiness Review process.</td></tr>
<tr><td>20.</td><td>Section 4.0.C.1: Member Services</td><td>Member Services</td><td>Is it acceptable to maintain two member services call functions – a plan’s general member services line (with increased training on carve-in and HARP services) and a BH service line for assistance in accessing care, speaking to a care manager, seeking urgent assistance? The BH line would not be used to handle typical member issues, such as requesting a replacement ID card, a replacement copy of a handbook, etc. The process for hands offs to the BH line would be described in order to show how the two centers work together.</td><td>It is acceptable to maintain two member services call functions, as long as the BH services call center staff have knowledge on:

i. Covered services;
ii. NYS managed care rules;
iii. Approved BH UM criteria;
iv. Approved HCBS rules and requirements (for HARPs); and
v. Provider networks

The Plan would need to describe how the two lines work together and how data, physical and behavioral health, will be integrated and available to both behavioral health and general member services personnel.</td></tr>
<tr><td>21.</td><td>Section 4.0.D.1: Network Management</td><td>Network Management</td><td>Describe the specific service area [county or counties] in the responder’s current Medicaid managed care contract with NYS including anticipated enrollment and utilization, and the cultural, linguistic and other demographic information that will influence network development.
Can you please provide guidance on the best approach for responding to this question?</td><td>The State recommends outlining your response in the following way:

<table>
<tr><th colspan="2">Service Area Population Characteristics</th></tr>
<tr><td></td><td>Percentage of Service Area Population</td></tr>
<tr><td>Gender</td><td></td></tr>
<tr><td>Male</td><td></td></tr>
<tr><td>Female</td><td></td></tr>
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				<table><tr><td>Race/Ethnicity</td><td></td></tr><tr><td>White non-Hispanic</td><td></td></tr><tr><td>Black non-Hispanic</td><td></td></tr><tr><td>Asian</td><td></td></tr><tr><td>Other non-Hispanic</td><td></td></tr><tr><td>Hispanic</td><td></td></tr><tr><td>Limited English Proficiency</td><td></td></tr><tr><td>Lesbian, Gay, Bisexual, Transgender (LGBT), Heterosexual, and Other/Non-conforming</td><td></td></tr></table>
22.	Section 4.0.D.2: Network Management	General	Please clarify the page limit for Question 2.	The page limit for this question is one (1)
23.	Section 4.0.D.10: Network Management	Network Management	"Describe at least one (1) goal, strategy, and measureable outcome, from a public sector client, where improvements occurred in the availability of and member engagement in culturally appropriate BH services (as defined in Section 2.0 of the RFQ). Identify the customer reference(s) that can verify this experience. Please note in your response if staff experience is being claimed as discussed in Section 3.2 and fill out the response accordingly. Include the specific staff that meet the experience requirement and their role in the Mainstream MCO and HARP." Question: Please clarify if MCOs applying without a BHO are to respond to this question.	Yes, this question applies to all Plans.

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24.	Section 4.0.D.12.b: Network Management	Network Management	This RFQ would require plans to make completion of cultural competency training required for successful credentialing. While an admirable goal, this would have a negative impact on network adequacy for plans whose providers do not timely complete such training. Also, since this RFQ does not permit a plan to credential individual providers in state clinics, by default this provision would only apply to non-clinic providers. It would then be inequitably applied to BH providers. At this time, please clarify whether completion of such training could be reworded in the RFQ as a goal, not a requirement.	NYS expects Plans to train, but it is not a condition of the credentialing process, all BH providers including OMH/OASAS licensed and certified credentialed providers. Plans should work together to develop a unified training curriculum.
25.	Section 4.0.D.16: Network Management	Network Management	"Provide an example of how the responder has assisted another government/public sector managed BH or similar client to successfully move from fee-for-service to managed care/capitation or to implement payment reform with network providers. Include the challenges and strategies to overcome those challenges. Identify the customer reference(s) that can verify the experience described." Question: Please clarify if this question is only for BHOs applying on behalf of an MCO.	Yes, this question applies to all plans.
26.	Section 4.0.D.19: Network Management	Guidance	Please provide an anticipated release date for the crisis services guidance that the RFQ indicates is in development.	NYS will be providing information on network requirements for crisis services in the near future.

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27.	Section 4.0.D.26: Network Management	Network Management	"Provide an example of how the responder has developed or transformed another public sector MH and SUD provider network to successfully achieve system goals and operating principles similar to those outlined in the RFQ. Include the challenges and strategies to overcome those challenges. Please relate this experience to your plan for BH in NYS. Identify the customer reference(s) that can verify the experience described. Please note in your response if staff experience is being claimed and fill out the response accordingly. Include the specific staff that meets the experience requirement and their role in the Mainstream MCO and HARP. Alternatively, if you do not have this experience, describe your planned approach to achieve the systems goals in this RFQ and describe the anticipated challenges. Question: Please clarify if MCOs intending to manage the BH services without a BHO should also answer this question and provide information on their current network and any augmentation efforts.	Yes, Plans claiming staff experience and Plans utilizing a BHO should respond to this question. Please include either specific staff that meet the experience requirement and their role in the Mainstream MCO and HARP or describe your planned approach to achieve the systems goals in this RFQ and describe the anticipated challenges.
28.	Section 4.0.E.3: Utilization Management	HCBS	Would the State clarify that denials of services for HCBS would be administrative denials with grievance appeal rights.	Appeals of the HCBS assessment would be through a fair hearing process and denials for access to individual HCBS would be through a grievance and appeals process. UM guidelines are being developed by NYS and the Health Plan Association will address questions related to prior authorization, denials, and appeal processes.

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29.	Section 4.0.E.3.a: Utilization Management	HCBS	Please indicate the anticipated release date for the uniform criteria/guidance for PROS and HCBS referenced in this section.	NYS issued guidance related to UM for PROS on August 6th, 2015. NYS continues to work with the Health Plan Association on the UM guidance for HCBS. This information will be posted on the State agency websites.
30.	Section 4.0.F.2.j: Clinical Management	Clinical Management	F.2.j- "Which providers (both inpatient and outpatient) will receive performance reports and how often;" What are the expectations for such reporting. While billable screenings are identifiable in plans' claims records, referrals to other services would not be readily accessible without medical record review.	NYS is not issuing specifications for such reports. Plans should propose a process for monitoring provider performance including how information will be relayed to the provider.
31.	Section 4.0.F.2.g: Clinical Management	Guidance	Please clarify that guidance for integrated treatment can be required by plans via policy (and inclusion in the provider manual) rather than in contract. Plan contracts already contain provisions binding providers to plan policies.	In the response to the RFQ the Plan should describe what guidance they propose for their provider contracts versus policy conveyed in the provider manual.
32.	Section 4.0.F.7: Clinical Management	Contract	Please clarify that the references to contract requirements can be met with institution of new policies. Contracts currently contain provisions that bind providers to plan policies, including the topics/areas included in this section.	The Plans will need to amend their provider contracts to conform with the requirements in the Managed Care Contracts with the State.
33.	Section 4.0.I.1.b: Reporting and Data Management	Reporting	I.1.b.-"Describe an experience with receiving and loading provider information to accommodate a state's BH provider network. If staff experience is claimed, please note this and answer accordingly." Question: Please clarify if this question is applicable only to BHOs. Plans load and submit provider data regularly to the state currently. Is	Yes, Plans claiming staff experience and Plans utilizing a BHO should respond to this question.

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			that what a health plan applying on its own should describe?	
34.	Section 4.0.J.1: Claims Administration	Claims	J.1- Describe the responder's experience for processing Medicaid claims specific to those services being added under the RFQ, including prior and current clients, type of claims administration (ASO or at risk), and the number of covered lives." Plan Question: Please clarify how a plan applying without a BHO should respond to this question. While plans process considerable BH claims now, the new services to be carved in may not have been part of its current claims experience. Should plans report on their current claims processing capabilities?	Yes, Plans should report on their current claims processing capabilities and changes necessary for BH services claims to be processed. Also, Plans not using a BHO should indicate how they will bring in the expertise to understand new behavioral health programs and their reimbursement.
35.	N/A	Finance	Please clarify whether risk mitigation for upstate HARPs will include risk corridors in addition to stop loss.	Yes, the same general provisions as for the NYC HARPs will apply. NYS will be issuing guidance in the near future.
36.	Section 4.0.K.4: Financial Management	Finance	Please clarify if this section applies only to HARP applicants. The requirements do not make sense otherwise for a benefit carve-in.	Yes, this question applies only to HARP.
37.	Section 4.0.K.5: Financial Management	Finance	Please clarify if this section applies only to HARP applicants.	Yes, this question applies only to HARP.
38.	Attachment B	Reporting	1. Reporting requirement including CMS assurances/sub's for HH and HCBS: a. How will Homeless, TAY, FEP, AOT, Criminal	Detail for reporting requirements is not yet available. The Federal assurance and sub assurance requirements are being finalized. Additional

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			Justice involved be defined and how will the plan be notified? b. Can the State provide clarity on actual reporting requirements with definitions? c. What are the implications for reporting on the HCBS services? Any additional detail the state can provide?	information will be forthcoming.
39.	Attachment E: Section C	Utilization Management	Please define “timeliness” as it relates to recovery plan submission, approval/rejection, and resubmission.	Details around the requirements for HCBS assurances and sub assurances are being developed