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Transition of Behavioral Health Benefit into Medicaid Managed Care and Health and Recovery Program Implementation

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Overview of Transition

The New York State Office of Mental Health (OMH), and the New York State Office of Alcohol and Substance Abuse Services (OASAS), in collaboration with the New York State Department of Health (DOH), are transitioning the full Medicaid behavioral health system to managed care. The goal is to create a fully integrated behavioral health (mental health and Substance Use Disorder) and physical health service system that provides comprehensive, accessible, and recovery oriented services. There are three components of the transition: expansion of covered behavioral health services in Medicaid Managed Care, elimination of the exclusion for Social Security Income (SSI), and implementation of Health and Recovery Plans (HARPs).

All Medicaid Managed Care Organizations (MMCO) ***must*** qualify in order to manage the expanded behavioral health services. Selected Managed Care Organizations (MCOs)[1] will manage the care for individuals with serious mental illness and/or Substance Use Disorders in a manner designed to improve health and functional outcomes. For Medicaid Managed Care (MMC), all Medicaid funded behavioral health services, with the exception of services in Community Residences, will become part of the benefit package. Services in Community Residences and the integration of children's behavioral health services will move to Medicaid Managed Care at a later date.

In addition to the expansion of covered behavioral health services in the MMC benefit package, New York State is eliminating the exclusion of behavioral health services for Medicaid Managed Care enrollees with SSI. This will require Medicaid Managed Care enrollees with SSI to access these services through the plan, rather than through the Medicaid Fee for Service program.

As part of the transition, DOH will also begin phasing in enrollment of current MMC enrollees into Health and Recovery Plans, or HARPs, beginning with adults 21 and over in New York City. This transition will then expand to the rest of the State. Some MCOs have elected to become qualified to operate a new product line called a Health and Recovery Plan (HARP). HARPs are Special Needs Plans that include specialized staff with behavioral health expertise. HARPs will provide all covered services available through Medicaid Managed Care, in addition to an enhanced benefit package that includes Behavioral Health Home and Community Based Services (BH HCBS) for eligible enrollees. These services are designed to provide the enrollee with specialized supports to remain in the community and assist with recovery. Enrollees must undergo an assessment to determine BH HCBS eligibility, and if eligible, the specific BH HCBS for which they are eligible. For the first two years of operation, HARPs will not be at risk for the management of the BH HCBS benefit. In addition, all HARP enrollees are eligible for individualized care management.

The transition is designed to foster a partnership among MCOs, government, service providers, Medicaid members, and families that promotes an environment that is person centered, recovery-oriented, and integrated where enrollees receive the care that is necessary to achieve a successful recovery.

The current timeline for the adult behavioral health transition is as follows:

- October 1, 2015 – NYC Medicaid Managed Care Plans, HIV Special Needs Plans (HIV SNP) and HARPs implement expanded non-HCBS behavioral health services for enrolled members.
- October 2015 -- January 2016 – NYC HARP enrollment is phased in.
- January 1, 2016 – BH HCBS become available to qualified HARP and HIV SNP enrollees.

[1] When the term "MCO" is used it applies to the Medicaid Managed Care plan, HARP, and/or HIV SNP.

- July 1, 2016 – Rest of State Medicaid Managed Care Plan Behavioral Health Management and Phased HARP Enrollment Begins.
- January 1, 2017 – NYC and Long Island Children's Transition to Medicaid Managed Care.
- July 1, 2017 – Rest of State Children's Transition to Medicaid Managed Care.

This guidance will be updated whenever there is a change in policy. Notice of changes will be sent to plans and posted as necessary.

I. Health and Recovery Plan Eligibility and Enrollment

New York State identified the initial cohort of individuals eligible for voluntary HARP enrollment based on specific utilization criteria for certain behavioral health services. The HARP eligible cohort is comprised of current enrollees in both MMCPs and HIV SNPs. The State will continue to identify current Medicaid Managed Care plan enrollees meeting the criteria for voluntary HARP enrollment eligibility on a quarterly basis. Individuals will be notified of their HARP eligibility and plan enrollment options through established processes. Processes for community referrals for determination of HARP enrollment eligibility are currently under development.

II. Behavioral Health Home and Community Based Services

1. Introduction

The Centers for Medicare and Medicaid Services (CMS) authorized various BH HCBS under Medicaid waiver authority. BH HCBS are designed to help adults (21 and over) with serious mental illness and/or Substance Use Disorder remain and recover in the community and reduce preventable admissions to hospitals, nursing homes, or other institutions.

BH HCBS address isolation and promote integration by providing a means by which individuals may gain the motivation, functional skills, and personal improvement to be fully integrated into the community and achieve life goals. The goal of integrating BH HCBS into the managed care environment is to promote significant improvements in the behavioral health system of care and move toward a recovery-based managed care delivery model. The recovery model of care, as envisioned in the HARP and HIV SNP models, emphasizes and supports an individual's recovery by optimizing quality of life and reducing symptoms of mental illness and Substance Use Disorders through empowerment, choice, treatment, education, employment, housing, and health and well-being.[2]

HARPs and HIV SNPs provide BH HCBS as a covered benefit for qualified members. HARPs and HIV SNPs must create an environment where the plan, service providers, plan members, families and other significant supporters, and government partner to assist members in prevention, management, and treatment of physical and behavioral health conditions, including serious mental illness and Substance Use Disorders.

2. BH Home and Community Based Services List

The following BH HCBS are included in the HIV SNP and HARP benefit package:

- Psychosocial Rehabilitation
- Community Psychiatric Support and Treatment
- Habilitation
- Family Support and Training
- Short-term Crisis Respite
- Intensive Crisis Respite
- Education Support Services
- Empowerment Services - Peer Supports
- Pre-vocational Services
- Transitional Employment
- Intensive Supported Employment
- Ongoing Supported Employment
- Non-Medical Transportation[3]

The Home and Community Based Services Manual includes specific information for each service including: service definitions and descriptions, provider qualifications, eligibility criteria,

[2] The State is continuing to work with CMS to develop a "Self-Directed Care" Pilot project, which will enable individuals in participating HARPs and HIV SNPs to be given employer authority and budget decision-making authority with regard to BH HCBS, as well as access to self-directed funds to purchase goods and services related to his or her recovery.

[3] Non-Medical Transportation will be carved out of the MCO benefit, managed by a Medicaid Transportation Manager based on the Plan of Care, and paid FFS directly to the transportation provider. In addition to Non-Medical Transportation, transportation to BH HCBS included in an individual's Plan of Care will be treated the same way as medically necessary Medicaid Transportation. Please see Section on Non-Medical Transportation for additional plan requirements for this service.

limitations/exclusions, allowed modes of delivery, service delivery settings, practitioner credentials for service provision, and caseload ratios.

3. BH HCBS Eligibility and Assessment

HARPs and HIV SNPs will coordinate with Health Homes or another State-designated entity to complete a brief eligibility assessment for BH HCBS for all HARP enrollees or HARP eligible HIV SNP enrollees as required by CMS. The BH HCBS Eligibility Assessment ("Assessment") contains some elements from the NYS Community Mental Health Suite of the InterRAI Functional Assessment tool.

For HARP members enrolled in Health Home (HH) care management, the individual's HH care manager works with him or her to complete the BH HCBS Assessment. The Assessment determines eligibility for BH HCBS, and the appropriate level and type of services needed. A member may be eligible for Tier 1 (employment services, education support services, peer support services) or Tier 2 (the full array) of BH HCBS. Once the individual is deemed eligible to receive BH HCBS, the HH care manager will conduct a full assessment using the entire NYS Community Mental Health Suite of the InterRAI. The HH care manager will conduct a re-assessment of BH HCBS needs on an annual basis for all members in receipt of such services, or after a significant change in the member's condition such as an inpatient admission or a loss of housing.

For HARP members who elect not to enroll in Health Home care management, the HARP and HIV SNP must arrange for completion of the assessment process through subcontracts with Health Homes or other entities designated by the State for this purpose.

4. Developing the Plan of Care

For HARP and HIV SNP members receiving HH care management, the HH the care manager utilizes the information in the full assessment to work with the individual to develop a plan of care that meets CMS requirements for HCBS.

As part of development of the plan of care, the HH care manager is responsible for assisting the member in selecting providers from his or her HIV SNP or HARP provider network for each BH HCBS in the individual's plan of care. All BH HCBS provider selections are to be included in the plan of care, including provider selections for other physical and behavioral health services, and non-Medicaid services. The HH care management provider is responsible for ensuring that the individual is given choice of providers in the network. The provider selection process must meet conflict-free care management requirements established by CMS. The HARP or HIV SNP is responsible for assuring that BH HCBS provider selections are conflict-free.

After the plan of care is developed, the HH care manager submits the completed plan of care to the member's HARP or HIV SNP for authorization. The HARP or HIV SNP is responsible for authorizing the plan of care.[4] If the individual does not meet the functional need for BH HCBS through the Eligibility Assessment, the plan of care cannot include BH HCBS. The HH care manager will facilitate the referrals for the members to the providers of each BH HCBS. The HARP or HIV SNP is responsible for ensuring members have access to the services identified in the plan of care.

For HARP and HIV SNP members who decline HH care management and who are eligible for BH HCBS after completion of the assessment process, the HARP or HIV SNP must arrange for completion of the

[4] The requirement that the MCO shall be responsible for approving the plan of care shall initially only apply for enrollees for whom BH HCBS have been recommended. Upon 60 days' notice from SDOH and subject to the availability of the operational systems to support such review, the MCO shall review and approve plans of care for all enrollees. The Contractor may also request the plan of care for any Enrollee, as deemed clinically necessary.

BH HCBS plan of care through subcontracts with Health Homes or other entities designated by the State for this purpose. Once the plan of care is completed, the Health Home or other entity designated by the State submits the plan of care to the HARP or HIV SNP. The HARP or HIV SNP is responsible for approval and implementation of the BH HCBS plan of care.[5]

The BH HCBS providers must adhere to appointment availability standards as outlined in Appendix T of the MEDICAID MANAGED CARE/ FAMILY HEALTH PLUS/ HIV SPECIAL NEEDS PLAN MODEL CONTRACT (Managed Care Contract) between the State and the MCOs.

The HIV SNP or HARP is responsible for documenting compliance with CMS Assurances and Sub-Assurances. CMS Assurances are found in the Special Terms and Conditions of the New York State Section 1115 Partnership Plan Waiver and the Managed Care Contract. To date, CMS Sub-Assurances have not been finalized.

5. BH HCBS Assessment Appeal Process

If an individual is assessed or re-assessed for BH HCBS and disagrees with the BH HCBS assessment, he or she may request a fair hearing to appeal the determination. The individual may also make a timely request for "aid to continue" while he or she awaits the outcome of the fair hearing. The right to receive "aid to continue" only extends to individuals who are already receiving a BH HCBS, but not where an individual has been denied a request for a new service.

6. Non-Medical Transportation

If non-medical transportation is indicated in an individual's plan of care, the HARP or HIV SNP, in addition to approving the plan of care, will be responsible for forwarding the "NYS BH HCBS Plan for Transportation Grid" (Grid) completed by the Health Home Care Manager (found in the table below) to the Transportation Manager once the plan of care is approved and any time there are changes to the plan of care. In the instances that an individual is not enrolled in a Health Home, the HARP or HIV SNP will be responsible for completing the Grid based on the individual's plan of care and forwarding to the Transportation Manager. The Grid should include documentation for non-medical transportation including documentation of which service in an individual's plan of care the trips will be tied to, such as going to a job interview.

The "NYS BH HCBS Plan for Transportation Grid" is completed by the HARP or HIV SNP based on the participant's plan of care and includes the following information:

- Participant information
- BH HCBS provider information
- Non-medical transportation service
- Supporting information includes:
    - Goal from the plan of care
    - BH HCBS or specific activity/support/task
    - Mode of transportation service needed
    - Trip destination/location
    - Start date/end date
    - Frequency

[5] Please see Section V. 4, BH HCBS Utilization Management for detailed information on HCBS Assessment and POC development

The MCO will share the completed Grid with the Medicaid Transportation Manager any time there are changes to this Grid.

NYS BH HCBS Plan for Transportation Grid

1. Participant Information

Participant Name: _____
DOB: _____
Care Management Program: _____Medicaid ID: _____
Date of Plan: _____
Address _____ City _____ County _____ Zip code _____

2. MCO Information

MCO _____ Telephone _____
Fax _____
County _____ Address _____ City _____State _____ Zip code _____

3. Transportation Provider Information

Transportation Provider _____ NPI _____ Telephone _____
Fax _____
County _____ Address _____ City _____ State _____ Zip code _____
Transportation Provider _____ NPI _____ Telephone _____ Fax _____
County _____ Address _____ City _____ State _____ Zip code _____
Transportation Provider _____ NPI _____ Telephone _____ Fax _____
County _____ Address _____ City _____ State _____ Zip code _____

4. Non-Medical Transportation

Goal (from Plan of Care)	BH HCBS or Specific Activity/ Support/ Task	Type of Transportation Service Needed	Trip Destination/ Location	Start Date/ End Date	Frequency

Date _____ Completed By_____ Telephone_____ Email_____
Fax_____

7. BH HCBS Provider Network

BH HCBS provider network standards were established to ensure network adequacy and timeliness of access to services for each type of BH HCBS. Details of the network requirements can be found in the Managed Care Contract and Section III.4 of this guidance.

8. BH HCBS Service Limits

For at least two years, HARPs and HIV SNPs will be reimbursed by the State for BH HCBS services on a non-risk basis outside the capitation rate by submitting claims under supplemental rate codes. CMS requires utilization limits on individual and overall cumulative BH HCBS. HARPs and HIV SNPs are responsible for monitoring these limits. The service thresholds are limited within a 12-month calendar period per individual. Limits are defined by tier and individual discrete service in terms of dollars and/or units.

- Tier 1 includes Peer Support Services, Education Support Services and Individualized Employment Support Services (IESS includes: Pre-vocational, Transitional Employment, Intensive Supported Employment, and Ongoing Supported Employment).
- Tier 2 includes all of Tier 1 plus Psychosocial Rehabilitation, Community Psychiatric Support and Treatment, Habilitation, and Family Support and Training.

Each individual BH HCBS has its own hours limits. In addition, there are aggregated dollar limits as follows:

- Tier 1 BH HCBS services will be limited to $8,000 as a group. There will also be a 25% corridor on this threshold that will allow HARPs and HIV SNPs to go up to $10,000 without a disallowance.
- There will also be an overall cap of $16,000 on BH HCBS services (Tier 1 and Tier 2 combined). There will be a 25% corridor on this threshold that will allow HARPs and HIV SNPs to go up to $20,000 without a disallowance.
- Both Tier 1 and Tier 2 are exclusive of crisis respite. The two crisis respite services are limited within their own individual caps (7 days per episode, 21 days per year).

If a HARP or HIV SNP anticipates the BH HCBS recipient will exceed any limit for clinical reasons, it should contact the OMH or OASAS medical director and obtain approval for a specific dollar increase above the $8,000, $16,000, or crisis stay effective limits. MCOs are not financially responsible for any BH HCBS not appearing on the approved plan of care based on the functional assessment.

9. Federal Requirements for BH HCBS Settings

CMS regulatory requirements for Behavioral Health Home and Community-Based Settings require BH HCBS to be delivered in settings that meet defined criteria for "home and community-based settings".[6] CMS also clarifies those settings that do not qualify as "home and community-based settings". Individuals residing in these non-qualifying settings may not receive BH HCBS.

Settings that do not qualify as "home and community-based settings" per federal regulation include:

- A nursing facility
- An institution for mental diseases (IMD)
- An intermediate care facility for individuals with intellectual disabilities
- A hospital
- Any other settings that have the qualities of an institutional setting[7]

[6] See 42 CFR §§ 441.301(c) and 441.710(a).
[7] 42 CFR §§ 441.301(c)(5) and 441.710(a)(2).

Settings presumed to have the qualities of an institutional setting, unless documented otherwise, include:

- Any setting located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment;
- Any setting located in a building on the grounds of, or immediately adjacent to, a public institution;
- Any other setting having the effect of isolating individuals receiving Medicaid BH HCBS from the broader community of individuals not receiving Medicaid BH HCBS.

10. Oversight of BH HCBS Providers

Once agencies begin providing BH HCBS, the State and, for New York City-based providers, the New York City Department of Health and Mental Hygiene (DOHMH), will coordinate and conduct site visits to ensure compliance with the BH HCBS standards as defined in the BH HCBS Manual. During start-up, site visits may be conducted specific to the BH HCBS providers to ensure compliance with standards. Ultimately BH HCBS oversight will be attached to OMH and OASAS licensing and/or performance monitoring visits. The State will create a BH HCBS review protocol that licensing and/or other program oversight staff will complete on regular licensing/monitoring visits. Review results will be reported to the BH HCBS Oversight Committee, whose membership includes staff from DOH, OMH, OASAS and, for New York City-based providers, DOHMH. If findings indicate there is non-compliance with BH HCBS standards, the provider will submit a corrective action plan for deficiencies to the BH HCBS Oversight Committee. If there is non-adherence to the corrective action plan, the committee will have the authority to withdraw designation from a provider.

Pursuant to the Managed Care Contract, HARPs and HIV SNPs are responsible for monitoring BH HCBS provider performance. Additionally, HARPs and HIV SNPs should report concerns to the BH HCBS Oversight Committee. Prior to terminating a relationship with a BH HCBS provider, the HARP or HIV SNP must notify the State of its concern and request the provider to submit a corrective action plan addressing performance issues within 45 days.

11. BH HCBS Providers without Medicaid Billing Experience

A small percentage of BH HCBS providers lack experience billing Medicaid. These providers may not have Medicaid compliance programs in place prior to the start of BH HCBS provision. For these providers, the State will provide technical assistance to ensure access to the systems that conduct criminal background checks and fingerprinting as well as the Statewide Central Register for Child Abuse and Maltreatment (SCR). HARPs and HIV SNPs should offer these providers additional assistance with items such as claims processing and payment, service authorizations, documentation, recordkeeping, and Medicaid compliance. Intensive outreach to these providers may be necessary to help transition them into managed care provider networks.

12. Ongoing Training for BH HCBS Providers

In collaboration with Columbia University's Center for Practice Innovation and CASAColumbia, the State has established the Managed Care Technical Assistance Center to develop and deliver a training curriculum for BH HCBS providers. This training allows providers to access the latest information on promising, best and evidence based practices, specific treatment modalities, and interventions that relate to the provision of BH HCBS. The training is mandatory for BH HCBS providers, is provided at no charge to providers and is one element in the BH HCBS Review Protocol to ensure that providers adhere to the training requirements. This is a resource to ensure that the BH HCBS providers in the network have received appropriate training and education on these services.

III. Behavioral Health Network and Contracting

1. Introduction

This Section describes the requirements for network adequacy for behavioral health services provided through MCOs. Network adequacy requirements were developed as part of a collaborative process between DOH, OMH, and OASAS. Stakeholder and Medicaid Redesign Team feedback was gathered on the State's proposed network requirements and was incorporated where possible.

2. Network Adequacy for Behavioral Health Services

A. General Principles

To ensure network adequacy and timely access to behavioral health services, including each type of BH HCBS, MCOs must consider multiple factors in network development. Services must be geographically accessible, meaning that standards relating to travel time and distance must be met. Also, the number of behavioral health providers in each service category included in the MCO's network must be adequate to meet the demand for that service. In many areas, the minimum standards will not be enough to meet enrollees' needs. In this case, the MCO will be expected to contract with additional providers. For BH HCBS in particular, capacity of each provider for each service is another factor that must be considered. Where standards relating to staffing ratios and caseload limits have been set by the State for BH HCBS, these standards must be incorporated into network development. Additionally, recommended appointment availability standards, as outlined in the Managed Care Contract, must be met. Each MCO should ensure it has adequate provider relations staff to support the existing and future development of the network.

B. Mental Health Clinic Network Adequacy

i. A minimum adequate network of mental health clinics (clinics) must include 50% of the total sites operated by clinic providers in the county (or region for rural counties—see definitions below). If an MCO meets the minimum number of required clinic sites for a county from clinics operated by one entity, it must contract with at least one separate entity in that county, so as to offer choice to the member. When the MCO contracts with an entity, it must contract with all the clinic sites, including satellites – however satellites will not count toward the minimum required number of sites.

ii. State-operated clinics do not count towards the 50% network adequacy requirement. For more information, refer to State-issued "Guidance on Managed Care Contracting and OMH State-Operated Services."

iii. Until the children's behavioral health benefit is moved into managed care, clinics contracted to meet the minimum network requirement must serve adults. Clinics that solely serve children and adolescents will not count towards minimum network requirements. MCOs which contract with Licensed Children's Clinics or child serving clinics must continue

As of July 2015, the following table shows the minimum number of clinic sites serving adults required to be under contract in NYC:

	Voluntary (50% of total in county)	**State Operated (All)**
Bronx	16	1
Kings	24	8
New York	28	3
Queens	21	3
Richmond	4	2

C. Network Adequacy for PROS, CDT, and IPRT

The minimum adequate network for Personalized Recovery Oriented Services (PROS), Continuing Day Treatment (CDT), and Intensive Psychiatric Rehabilitation Treatment (IPRT) would include 50% of the total sites of those three provider types in each county of the service area, with a minimum of two sites and two agencies, where available.

The table below describes the network minimum site requirement in each NYC Borough:

	Bronx	Kings	New York	Queens	Richmond
PROS, CDT* & IPRT	3	5	8	6	2*

*There is currently only one program of this type (CDT) operating in Richmond County, therefore the MCO must contract with a provider in a neighboring county to meet the minimum network requirement.

Where there are PROS programs within the county or region, the MCO must contract with the PROS programs first to meet its minimum network requirement.

D. Substance Use Disorder Adult Network Adequacy:

OASAS	Urban	Rural	Guidance Comment
Opioid Treatment Programs	All programs (which will have multiple sites) per county, and for NYC – all programs (which will have multiple sites) in the city: Bronx: 7 Kings: 8 New York: 12 Queens: 4 Richmond: 1	All per region	OTPs are defined as "essential community behavioral health providers" and MCOs must contract with them as stated in section 21.19 of the Managed Care Contract. In rural areas OTP Programs are limited in number. Patients frequently have to travel across several counties to access OTP services. MCOs are required to contract with OTPS as necessary to ensure access and incorporate OTP Programs as allowable to support access and choice.
OASAS Outpatient Clinics	The higher of 50% of all licensed clinics (will have multiple sites) or minimum of 2 per county Bronx: 23 Kings: 33 New York: 46 Queens: 25 Richmond: 11	The higher of 50% of all licensed clinics or minimum of 2 per county	If an MCO meets the minimum number of required clinic sites for a county from the clinics operated by one entity, they must contract with at least one separate entity, so as to offer the member choice. When the MCO contracts with an entity, it must contract with all the clinic sites.
Buprenorphine prescribers	All licensed prescribers serving	All licensed prescribers serving	The State is seeking to ensure access to Medication Assisted Treatment thus the requirement to

	Medicaid patients	Medicaid patients	contract with all Licensed Buprenorphine prescribers.
Inpatient Treatment	2 per county	2 per region	Refers to OASAS Certified Part 818 Inpatient Rehabilitation Programs
DETOXIFICATION			
Inpatient Hospital Detox	2 per county	2 per region	
Medically Supervised Inpatient Detox	2 per county	2 per region	Refers to OASAS Certified Part 816 Medically Supervised Inpatient Detoxification Programs
Medically Supervised Outpatient Withdrawal	2 per county	2 per region	Refers to OASAS Certified Part 816 Medically Supervised Outpatient Withdrawal Programs
OASAS Certified Residential Addiction Treatment Services	2 per county	2 per region	Where an enrollee is mandated by a court or LDSS into any OASAS certified residential program that is outside of the MCO's service area, the MCO must also contract with that OASAS residential program and pay the program's allied clinical (BH & PH) service providers on either a single case basis, or incorporate such residential program and its allied programs into the MCO's provider network

E. Credentialing of OMH Licensed and OASAS Certified Providers

As provided by the Managed Care Contract, when credentialing OMH-licensed, OMH-operated, and OASAS-certified providers, the MCO shall accept OMH and OASAS licenses, operation and certifications in place of, and not in addition to, any MCO credentialing process for individual employees, subcontractors or agents of such providers. The MCO shall collect and accept program integrity related information from these providers, as required in Section 18 of the Managed Care Contract, and shall require that such providers not employ or contract with any employee, subcontractor or agent who has been debarred or suspended by the federal or state government, or otherwise excluded from participation in the Medicare or Medicaid program.

Credentialing consists of two processes:

i. The assurance that individuals providing services possess the qualifications to provide such services.

   The State's licensing or certification of a provider will signify the behavioral health provider staff meet the program credentialing requirements. Accordingly, the MCOs must accept such licensing or certification as sufficient to meet the credentialing requirement.

ii. The assurance that individuals providing services have not been disqualified or de-barred from providing such services under the Medicare/Medicaid programs by federal or state government.

HARPs and HIV SNPs maintain the responsibility to ensure this function is performed pursuant to federal law. The MCO's credentialing committee shall develop and adhere to procedures that are consistent with 42 CFR 455.436 and Section 18.9 of the Managed Care Contract to ensure this responsibility is met. If a Plan determines that a practitioner providing a service at an Article 31 or 32 provider has been disqualified or de-barred, any claims submitted for services provided by such practitioner should be denied.

BH HCBS providers will be required, for all current or prospective operators, employees or volunteers of such providers who have regular and substantial unsupervised or unrestricted physical contact with the clients of such providers, to complete the 3 pre-employment background checks required for OMH-licensed and OASAS-certified providers. The 3 pre-employment background checks are as follows:

- The Justice Center's Criminal Background Check System
- The Staff Exclusion List
- The Statewide Central Register for Child Abuse and Maltreatment (SCR)-NB. Please be advised that this check is conducted through OCFS and can take weeks to complete.

Additional guidance and technical assistance on these processes will be forthcoming for providers who do not currently bill Medicaid.

4. Network Adequacy for BH HCBS [HARP and HIV SNP Only]

A. General Principles

Eligible members of HARPs and HIV SNPs will have the ability to access an enhanced benefit that includes an array of BH HCBS. BH HCBS provide opportunities for enrollees with mental illness and/or Substance Use Disorders to receive rehabilitation services in the community and in their own home. Implementation of BH HCBS will help members prevent, manage and recover from chronic behavioral and physical health conditions.

BH HCBS will be provided using the following core principles:

- Person-Centered
- Recovery-Oriented
- Integrated
- Data-Driven
- Evidence-Based
- Trauma-Informed
- Peer-Supported
- Culturally Competent
- Flexible and Mobile
- Inclusive of Social Network
- Coordination and Collaboration

- Additional guidance related to BH HCBS can be found in Section II and Section V.4 of this guidance.
- In order to access BH HCBS, HARP members and HARP eligible HIV SNP members must be assessed for BH HCBS eligibility.
- Entities that may provide BH HCBS must have been designated by New York State to provide BH HCBS. For full list of BH HCBS providers, see the Provider Designation List. Maps showing the location of providers as of July 14, 2015 can be found at the end of this guidance document.
- Definitions of BH HCBS services can be found in the NYS BH HCBS Provider Manual.
- If a HARP or HIV SNP identifies that an insufficient number of designated BH HCBS providers exist in a county, it should bring this to the attention of the State as quickly as possible.

- As of August 2015, BH HCBS providers serving HARP and HARP eligible HIV SNP members outside of NYC have not been designated. Designation will occur prior to the Rest of State (ROS) HARP implementation.
- Contracts between HARPs/HIVSNPs and BH HCBS providers must be approved by NYS.

B. Credentialing of BH HCBS Providers

As provided in the Managed Care Contract, when credentialing BH HCBS providers, the HARP or HIV SNP shall accept the State-issued BH HCBS designation in place of, and not in addition to, any plan credentialing process for individual employees, subcontractors or agents of such providers. The HARP or HIV SNP shall collect and accept program integrity related information from these providers, as required in Section 18 of the Managed Care Contract, and shall require that such providers not employ or contract with any employee, subcontractor, or agent who has been debarred or suspended by the federal or state government, or otherwise excluded from participation in the Medicare or Medicaid program.

Provider credentialing consists of two processes:

i. The assurance that individuals providing services possess the qualifications to provide such services.

   The State's designation of a provider as an approved BH HCBS provider will signify that the provider staff meets the program credentialing requirements. Accordingly, the HARP or HIV SNP must accept such designation as sufficient to meet this credentialing requirement.

ii. The assurance that individuals providing services have not been disqualified or de-barred from providing such services under the Medicare/Medicaid programs by federal or state government.

   HARPs and HIV SNPs maintain the responsibility to ensure this function is performed pursuant to federal law. The MCO's credentialing committee shall develop and adhere to procedures that are consistent with 42 CFR 455.436 and Section 18.9 of the Managed Care Contract to ensure this responsibility is met. If a Plan determines that a practitioner providing a service at an Article 31 or 32 provider has been disqualified or de-barred, any claims submitted for services provided by such practitioner should be denied.

C. BH HCBS Provider Selection Monitoring

HARPs and HIV SNPs will be responsible for monitoring BH HCBS provider selections by members and will maintain and submit to the State tracking reports of such selections, sorted by each Health Home downstream care coordination provider. The State will use this information to ensure that conflict free choice takes place between the care manager and the member as many Health Home care coordination providers have also been designated as BH HCBS providers.

D. BH HCBS Provider Training

Initial training plans and curricula for BH HCBS providers should be developed in collaboration with the State. Revisions or updates to training plans will be made in consultation with members, member supports, the Regional Planning Consortia, and the State. BH HCBS provider training and technical assistance must be coordinated across MCOs and should be delivered using different methodologies, including in-person and web-based, and offered at alternate times and days of the week. Initial training and technical assistance should include the following topics and always include a relevant cultural competence component:

i. Initial Orientation for behavioral health providers new to the HARP or HIV SNP network

ii. HARP Benefits, Eligibility and Enrollment
iii. BH HCBS Benefits, Eligibility and Enrollment
iv. Health Homes and Care Management
v. BH HCBS Assessments and the Plan of Care
vi. BH HCBS Individualized Recovery Plans
vii. Access to Member Records
viii. Documentation, Recordkeeping and Data Collection
ix. HARP Billable Services including Mainstream and BH HCBS Benefits
x. Utilization Management
xi. Billing and Coding, Claims Submission and Reimbursement Procedures
xii. Recovery-oriented Practices
xiii. Person-centered Planning
xiv. Operationalization of Best/ Promising/ Evidence-based Practices
xv. Service Delivery to Special Populations
xvi. Common Medical Conditions and Challenges

5. Crisis Intervention

A. Introduction

New York State has received demonstration authority from the federal government under Section 1115 of the Social Security Act for Crisis Intervention services. The CMS waiver approval authorizes the State to require all MCOs to include Crisis Intervention services in their networks. New York State's vision for this demonstration project is to develop a recovery-oriented and person-centered comprehensive local behavioral health (MH/SUD) crisis response system throughout the State. The purpose of this guidance is to identify the initial minimum network requirements for the Crisis Intervention Service.

B. Eligibility for the Service

Enrollees in MMC plans, HARPs, and HIV SNPs are all eligible for the Crisis Intervention service.

C. Description of the Service

Crisis Intervention services are provided to an individual who is experiencing or is at imminent risk of having a psychiatric crisis. The service is designed to interrupt and/or ameliorate a crisis. The service includes a preliminary assessment, immediate crisis resolution and de-escalation. Services should be geared towards preventing the occurrence of similar events in the future and keeping the individual as connected as possible with their environment and activities of choice. The goals of Crisis Intervention services are engagement, symptom reduction, and stabilization. All services must occur within the context of a psychiatric crisis.

Crisis Intervention services include the following components:

i. A preliminary assessment of risk, mental status, medical stability, and community tenure and the need for further evaluation or other mental health services. This includes contact with the individual, family members, and/or other collateral sources (e.g. caregiver, school personnel) with pertinent information for the purpose of a preliminary assessment, treatment and/or referral to other alternative mental health services at an appropriate level
ii. Crisis resolution and consultation with the identified Medicaid eligible individual and the treatment provider
iii. Referral and linkage to appropriate Medicaid behavioral health community services to avoid more restrictive levels of treatment

iv. Linkage to Short Term Crisis Respite or Intensive Crisis Respite when clinically appropriate
v. Contact with the individual, family members, or other collateral sources
vi. Short-term crisis interventions include crisis resolution and de-briefing with the identified Medicaid eligible individual and the treatment provider
vii. Follow-up with the individual, and when appropriate, with the individuals' caretaker and/or family members
viii. Follow-up with the individual and the individuals' family/supportive network which could be provided by a Certified Peer Specialist or Certified Peer Advocate in order to confirm linkage to Care Coordination, outpatient treatment or other services as appropriate
ix. Consultation with a physician or other qualified providers to assist with the individual's specific crisis and plans for the individual's future

D. Initial Minimum Network Requirements

To meet the standard for network adequacy for Crisis Intervention, MCOs must contract with a sufficient network of providers to deliver the Crisis Intervention service for enrollees in emotional crisis via phone, in person (if the individual presents for emergency care), and mobile response on a 24 hour basis. The service must be available immediately upon an individual's presentation for the service. No prior authorization may be required for Crisis Intervention services.

As with any service, MCOs must consider the following components in establishing a network for Crisis Intervention: anticipated enrollment and expected utilization of services, the geographic location of the providers and enrollees, the language and mobility/accessibility of providers, and enrollee choice.

These network requirements are expected to develop over time as a comprehensive local crisis intervention system is established throughout the State. To meet current standards for adequacy for Crisis Intervention, the network should be comprised of existing providers of the following crisis services: OMH Clinics, Comprehensive Psychiatric Emergency Programs (CPEPs), and designated BH HCBS Mobile Crisis providers. Each of these services is described below.

OMH Clinics

OMH clinics are required to offer Crisis Intervention services during operating hours as well as phone crisis response on a 24 hour per day/7 day per week basis. They are required to ensure an adequate response to service recipients and collaterals in need of assistance when the clinic is not in operation.
Clinic Crisis Intervention Services consist of three Medicaid reimbursable levels of service:

i. Clinic Crisis Intervention - Brief:
- This service may be provided face-to-face or by telephone.
- For services of at least 15 minutes duration, one unit of service may be billed.
- For each increment of at least 15 minutes, an additional unit of service may be billed, up to a maximum of six units per day.
- Brief Clinic Crisis Intervention Services can be reimbursed by Medicaid Fee for Service for individuals regardless of whether or not they have previously received services from the clinic.

ii. Clinic Crisis Intervention – Complex:
- This service requires a minimum of one hour of face-to-face contact by two or more clinicians.
- Both clinicians must be present for the majority of the duration of the total contact.
- A peer advocate, family advisor, or non-licensed staff may substitute for one clinician.

- Clinics may be reimbursed by Medicaid Fee for Service both for individuals currently enrolled in the clinic as well as those who have not engaged in services at their clinic for a period of up to two years.

iii. Clinic Crisis Intervention – Per Diem:

- This service requires three hours or more of face-to-face contact by two or more clinicians.
- Both clinicians must be present for the majority of the duration of the total contact.
- A peer advocate, family advisor, or non-licensed staff may substitute for one clinician.
- Clinics may be reimbursed by Medicaid Fee for Service both for individuals currently enrolled in the clinic as well as those who have not engaged in services at their clinic for a period of up to two years.

Comprehensive Psychiatric Emergency Programs (CPEP)

CPEP program objectives include providing timely triage, assessments, and interventions; controlling inpatient admissions; providing crisis intervention in the community; and providing linkages to other services. CPEPs are designed to directly provide or ensure the provision of a full range of psychiatric emergency services, seven days a week, for a defined geographic area.

The four required components of service are:

i. Hospital-based crisis intervention services in the emergency room, including triage, referral, and psychiatric and medical evaluations and assessments
ii. Extended observation beds in the hospital to provide for extended evaluation, assessment, or stabilization of acute psychiatric symptoms for up to 72 hours
iii. Mobile crisis outreach services in the community, including clinical assessment and crisis intervention treatment, with the goal of inpatient/emergency room diversion
iv. Crisis residence services in the community for temporary residential and other necessary support services for up to five consecutive days for individuals who have recently experienced a psychiatric crisis

Mobile Crisis Providers

This service was originally conceived as “mobile crisis” – a BH Home and Community Based Service that would only be available to individuals enrolled in HARP or HIV SNPs. However, mobile crisis and crisis diversion services are beneficial to the entire population of Medicaid enrollees and, in fact, all New Yorkers. As part of New York’s 1115 waiver authority, New York removed mobile crisis as a BH HCBS and replaced it with Crisis Intervention. Crisis Intervention is a mobile or onsite crisis response service that is available to any Medicaid Managed Care, HARP, or HIV SNP member.

Prior to this expansion, New York State designated 47 BH HCBS providers in New York City to provide the mobile crisis service. These providers are approved to provide the Crisis Intervention benefit to managed care enrollees.

E. Reimbursement for Crisis Intervention

i. Crisis Intervention is a network of individual services. There is no single rate code for Crisis Intervention services.
ii. MCOs will reimburse providers for each of the individual services described in Section D, above.
iii. The rates for reimbursement for each of the individual services are located in the New York State HARP Mainstream BH Billing and Coding Manual.

6. Initial Network Development in Rural Counties

A. Rural County Definition

For the purpose of network development, a rural county is defined as one with a population of fewer than 200,000 inhabitants.

Allegany, Broome, Cattaraugus, Cayuga, Chautauqua, Chemung, Chenango, Clinton, Columbia, Cortland, Delaware, Essex, Franklin, Fulton, Genesee, Greene, Hamilton, Herkimer, Jefferson, Lewis, Livingston, Madison, Montgomery, Ontario, Orleans, Oswego, Otsego, Putnam, Rensselaer, Schenectady, Schoharie, Schuyler, Seneca, St. Lawrence, Steuben, Sullivan, Tioga, Tompkins, Ulster, Warren, Washington, Wayne, Wyoming, and Yates are rural counties.

B. Region Definition

For the purpose of determining the adequacy of the Contractor's network in rural counties and for Essential Community Behavioral Health Providers, a region is defined as the catchment area beyond the border of a county, which includes the other counties of the State designated Regional Planning Consortium (RPC) region.

Regional Planning Consortium Regions	
Western NY	Allegany, Cattaraugus, Chautauqua, Erie, Niagara, Orleans, Genesee, Wyoming
Finger Lakes	Chemung, Livingston, Monroe, Ontario, Schuyler, Seneca, Steuben, Wayne, Yates
Southern Tier	Broome, Chenango, Delaware, Tioga, Tompkins
Central NY	Cayuga, Cortland, Madison, Oneida, Onondaga, Oswego
Mohawk Valley	Fulton, Herkimer, Montgomery, Otsego, Schoharie
North Country	Clinton, Essex, Franklin, Hamilton, Warren, Washington
Tug Hill Seaway	Jefferson, Lewis, St. Lawrence
Capital Region	Albany, Columbia, Greene, Saratoga, Schenectady, Rensselaer
Mid-Hudson	Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster, Westchester
Long Island	Nassau, Suffolk
New York City	Kings, Queens, Richmond, Bronx, New York

C. Meeting Network Requirements in the Case of Insufficient County Providers

If the providers in the county are insufficient to meet network requirements, MCOs must first contract with providers in neighboring counties to meet network requirements. If this is still insufficient, the MCO must then contract with providers within the RPC region. Consistent with current DOH approval processes, if the providers in the RPC region are insufficient to meet the minimum network requirement for the service, or the demand in the service area, the MCO must contract with providers in the next contiguous service area. For example, if an MCO service area includes Rensselaer County, and the Capital Region RPC has an insufficient number of Opioid Treatment Programs to meet the demand of the enrollees, then the MCO must contract with providers from the Mohawk Valley Region, North Country Region or Mid-Hudson Region, or any combination of regions, to build a sufficient network.

D. Reimbursement of Non-Participating Providers in the Case of Inadequate Network

MCOs whose networks are inadequate will be required, upon enrollee request, to permit enrollees eligible for services to receive services at a non-participating provider and reimburse those Behavioral Health Providers at no less than the Medicaid Fee for Service (FFS) rate.

7. Special Populations

The MCO shall develop a behavioral health network based on the anticipated needs of special populations, including but not limited to:

- Transition age youth with behavioral health needs. Transition age youth is defined as individuals between the ages of 18-21, transitioning into the adult system from any child serving system.
- 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, homeless, 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, including Adult Homes and Nursing Homes
- Individuals with SMI/SUD transitioning from jail/prison/courts
- Individuals in Assisted Outpatient Treatment (AOT) status

8. Primary Care Providers in Behavioral Health Clinics

As provided in the Managed Care Contract, MCOs are permitted to use Primary Care Providers (PCPs) employed by behavioral health clinics, including: mental health clinics operated pursuant to OMH regulations 14 NYCRR Part 598 or 599; OASAS-certified clinics, including OTPs certified pursuant to OASAS regulations 14 NYCRR Parts 816.8, 822, or 825; and Diagnostic and Treatment Centers (D&TCs), authorized pursuant to NYCRR Part 404. For HIV SNPs, including for HARP eligible enrollees, the PCP must be an HIV Specialist.

In order to promote increased access to physical and behavioral health services at a single site and to foster the delivery of integrated services based on recognition that behavioral and physical health are not distinct conditions, MCOs are expected to provide access to PCPs employed by behavioral health clinics.

- PCPs in BH clinics are not intended to be community providers available to all MCO members. The intent is to give members attending BH clinics the option to choose PCPs employed by clinics they are attending.
- When contracting with a licensed BH clinic, the MCO must contract for the full array of services the clinic is licensed to provide, including services provided by the clinic's PCPs.
- When credentialing OMH-licensed and OASAS-certified providers, the MCO accepts OMH and OASAS licenses and certifications in place of credentialing individual employees. However; the MCO should credential the PCPs employed by the BH clinics in the same manner as other PCPs are credentialed.

IV. Behavioral Health Transition Monitoring Report

As part of the Behavioral Health Services transition to Medicaid Managed Care, OMH will monitor the provision and reimbursement of services within the BH provider network. This is to ensure necessary services continue to be delivered and reimbursed during this transitional period.

1. Behavioral Health Transition Monitoring Report

OMH will develop a Behavioral Health Transition Monitoring Report as a management tool to assist the State, together with MCOs, Local Governmental Units (LGUs), and providers, in detecting system inadequacies as they occur, and enabling the State to initiate steps in addressing the issues as soon as possible. The report will consist of monthly, MCO specific data in three areas of concern during the transition to managed care: service use, denials, and timely payment to providers. Data on service use and timeliness of payment will come from Medicaid encounters, and information on denials will be collected through new monthly and quarterly MCO submissions.

2. Encounter Data Tracking

i. OMH and OASAS have developed templates to track behavioral health service utilization during the transition period. OMH will produce monthly utilization reports for all behavioral health services at the MCO level. This monitoring will allow the State to track trends in service use throughout the implementation period and identify potential disruptions in access to key services.

ii. To track timeliness of payment, OMH will examine dates of payment and dates of submission on encounter claims (available in the All Payer Database as of September 2015) relative to the service dates. This will allow the State to identify outliers in provider claims submission to plans, and payment from plans to providers. OMH will also monitor provider/MCO complaints.

3. MCO Data Submission

i. On a monthly basis, MCOs will be required to electronically submit a report to the State on all denials of continuing care for inpatient behavioral health services based on medical necessity. The report for a calendar month will be due on the fifteenth day of the next calendar month. The report will include aggregated provider level data for service authorization requests that resulted in a denial, whether the denial was Pre-Service, Concurrent, or Retrospective, and the reason for the denial.

ii. On a quarterly basis, MCOs will be required to electronically submit a report to the State on monthly BH ambulatory service denials aggregated at the MCO level by service. The submissions will include counts of denials for specific service authorizations as well as administrative denials, internal, and fair hearing appeals. In addition, HARPs will be required to report any denials of BH HCBS. Each quarterly submission will contain three separate months of data and will be due to the State fifteen days on the following month after the end of the quarter being reported.

V. Utilization Management

1. Prior authorization

This guidance regards utilization management for ambulatory behavioral health (BH) services that will be effective when the MCOs, including MMCPs, HARPs, and HIV SNPs assume management of these services in the adult Medicaid Managed Care Program. These services include routine outpatient office and clinic care as well as the full range of BH specialty services. MCOs will not use prior authorization for Medicaid BH outpatient office and clinic services as of the implementation of the behavioral health carve-in. MCO responses to the RFQ indicated the intent to minimize use of prior authorization for routine BH outpatient office and clinic services as it has proven an inefficient form of utilization management. In addition, parity requirements prohibit the imposition of non-quantitative treatment limits or benefit exclusions based on medical necessity or medical appropriateness when there are no such limits for similar medical/surgical services.

The following clarifies expectations of MCOs related to utilization management of routine behavioral health outpatient office and clinic care.

Note that:

1. *Prior Authorization Request* is a Service Authorization Request by the enrollee, or a provider on the enrollee's behalf, for coverage of a new service, whether for a new authorization period or within an existing authorization period, made before such service is provided to the enrollee.

2. *Concurrent Review Request* is a Service Authorization Request by an enrollee, or a provider on Enrollee's behalf for continued, extended or additional authorized services beyond what is currently authorized by the Contractor within an existing authorization period.

NYS expects MCOs to use the following utilization management and quality improvement approaches to oversee behavioral health outpatient office and clinic services:

1. *Clinical triggers for individual case reviews*. Examples include: XX outpatient visits for treatment of depression with no claims for antidepressant medications; multiple detox admissions for an individual with opioid dependence but no pharmacy claims for medication assisted treatment; no changes in intensity of outpatient services despite multiple inpatient readmissions; or claims suggesting quality of care concerns, e.g., a service type or frequency that clearly does not match an established evidence-based practice.

2. *Provider profile triggers for provider QA and education interventions*. Examples include: >XX% of clinic cases with specific diagnosis above the mean # sessions/year for all plan providers; or % cases with SUD and no mediation assisted treatment exceeds XXth percentile for all plan providers.

At this time, NYS will not define specific clinical or provider profile triggers that MCOs must use. OMH and OASAS MCO oversight staff will be available for consultation around development of specific triggers and request that MCOs submit their trigger definitions upon implementation.

Utilization management and quality improvement interventions should include recommendations for providers to review their practices and policies and should not involve retroactive utilization review. Providers will be expected to participate in MCO reviews of specific cases and provider profile data, and MCOs may deny services if providers fail to participate or make adequate efforts to address identified concerns.

In addition to the above recommended utilization management and provider education interventions:

1. NYS will allow MCOs to require concurrent review requests for outpatient mental health office and clinic services following the 30th visit paid by the MCO in a calendar year as described in the charts below.

2. UM Policies for outpatient Substance Use Disorder services (including opioid clinics) must be approved by OASAS;
   - 30-50 visits per year are within an average expected frequency for OASAS clinic visits.
   - 150-200 visits per year are within an average expected frequency for opioid treatment clinic visits.

   OASAS encourages MCOs to identify individual or program service patterns that fall outside of expected clinical practice but will not permit regular requests for treatment plan updates for otherwise routine outpatient and opioid service utilization. OASAS will issue further guidelines regarding use of the LOCATDR to support utilization management decisions for Substance Use Disorders.

As stated in prior guidance, MCOs are not permitted to deny payment for ambulatory BH services based upon failure of the provider to notify the MCO that an episode of ambulatory BH care has been initiated. NYS will work with MCO leadership to support alternative approaches to ensuring provider adherence to contracted notification requirements.

Ambulatory Mental Health services for adults for which Mainstream Managed Care, Health and Recovery Plans, and HIV Special Needs Plans may require prior and/or concurrent authorization of services

OMH licensed program type (and specific services, if appropriate)	Prior Authorization	Concurrent Review Authorization	Additional guidance
Mental health clinic including: initial assessment; psychosocial assessment; and individual, family/collateral, and group psychotherapy	No	Yes	MMCO/HARP/HIV SNP must pay for at least 30 visits per calendar year without requiring authorization. MMCO/HARP/HIV SNP must ensure that concurrent review activities do not violate parity law. Note: the 30-visit count should not include: a) FFS visits or visits paid by another MMCO/HARP; b) off-site clinic services; or c) psychiatric assessment and medication management visits. Multiple services received on the same day shall count as a single visit (and must be delivered consistent with OMH clinic restructuring regulations.
Mental health clinic services: psychiatric assessment; medication treatment	No	No	MH clinic visits exclusively for Medication Management or Psychiatric Assessment will not count towards the 30 visits per calendar year.
Mental health clinic services: off-site clinic services (also referred to as Other Licensed Practitioner services)	Yes	Yes	OMH will issue further guidance regarding off-site clinic services.
Psychological or neuropsychological testing	Yes	N/A	
Personalized Recovery Oriented Services (PROS) Pre-Admission Status	No	No	Begins with initial visit and ends when Initial Service Recommendation (ISR) is submitted to MCO. Providers bill the monthly Pre-Admission rate but add-ons are not allowed. Pre-Admission is open-ended with no time limit.
PROS Admission: Individualized Recovery Planning	Yes	No	Admission begins when ISR is approved by MCO. Initial Individualized Recovery Plan (IRP) must be developed within 60 days of the admission date. Upon admission, providers may offer additional services and bill add-on rates accordingly for: • Clinical Treatment; • Intensive Rehabilitation (IR); or • Ongoing Rehabilitation and Supports (ORS). Prior authorization will ensure that individuals are not receiving duplicate services from other clinical or BH HCBS providers.
PROS Active Rehabilitation	Yes	Yes	Begins when IRP is approved by MCO. Concurrent review and authorizations should occur at 3-month intervals for IR and ORS services and at 6-month intervals for Base/ Community Rehabilitation and Support (CRS) and Clinic Treatment services.
Mental Health Continuing Day Treatment (CDT)	Yes	Yes	

Mental Health intensive outpatient *(note: NOT State Plan)*	Yes	Yes	
Mental Health partial hospitalization	Yes	Yes	
Assertive Community Treatment (ACT)	Yes	Yes	New ACT referrals must be made through local Single Point Of Access (SPOA) agencies. MCOs will collaborate with SPOA agencies around determinations of eligibility and appropriateness for ACT following forthcoming NYS guidelines.

Ambulatory Substance Use Disorder services for adults for which Mainstream managed care, Health and Recovery Plans, and HIV Special Needs Plans may require prior and/or concurrent authorization of services.

Service	Prior Authorization	Concurrent Review Authorization	Additional guidance
OASAS Certified Part 822 clinic services, including off-site clinic services	No	Yes	See OASAS guidance regarding use of LOCATDR tool to inform level of care determinations. OASAS encourages MCOs to identify individual or program service patterns that fall outside of expected clinical practice but will not permit regular requests for treatment plan updates for otherwise routine outpatient and opioid service utilization; 30-50 visits per year are within an average expected frequency for OASAS clinic visits. MCOs will allow enrollees to make unlimited self-referrals for Substance Use Disorder assessment from participating providers without requiring preauthorization or referral from the enrollee's primary care provider. MMCO/HARP/HIV SNP must ensure that concurrent review activities do not violate parity law.
Medically supervised outpatient substance withdrawal	No	Yes	MCOs may require notification through a completed LOCADTR report for admissions to this service within a reasonable time frame.
OASAS Certified Part 822 Opioid Treatment Program (OTP) services	No	Yes	OASAS encourages MCOs to identify individual or program service patterns that fall outside of expected clinical practice but will not permit regular requests for treatment plan updates for otherwise routine outpatient and opioid service utilization; 150-200 visits per year are within an average expected frequency for opioid treatment clinic visits. MCOs will allow enrollees to make unlimited self-referrals for Substance Use Disorder assessment from participating providers without requiring preauthorization or referral from the enrollee's primary care provider. MMCO/HARP/HIV SNP must ensure that concurrent review activities do not violate parity law.
OASAS Certified Part 822 Outpatient Rehabilitation	No	Yes	MCOs may require notification through a completed LOCADTR report for admissions to this service within a reasonable time frame. MCOs will allow Enrollees to make unlimited self- referrals for Substance Use Disorder assessment from Participating providers without requiring preauthorization or referral from the Enrollee's Primary Care Provider. MMCO/HARP/HIV SNP must ensure that concurrent review activities do not violate parity law.

2. PROS Utilization Management

A. Introduction

Personalized Recovery Oriented Services (PROS) is one of the specialty behavioral health services that will be covered under the expansion of the Medicaid Managed Care benefit package. MCOs operating in New York City will assume management of this service in the adult Medicaid Managed Care Program beginning October 1, 2015. MCOs operating in other counties will begin managing specialty behavioral health services including PROS according to the previously established NYS timeline for integrated managed care.

B. Vision and definition of PROS

PROS is a comprehensive recovery oriented program for individuals with severe and persistent mental illness. Through a single plan of care, the program model integrates treatment, support, and rehabilitation in a manner that facilitates the individual's recovery. The PROS model is person-centered, strength based, and comprised of a menu of group and individual services designed to assist a participant to overcome mental health barriers and achieve a desired life role. As PROS is individualized, a person can participate in one service or multiple services as needed. Examples of goals for program participants are to: improve functioning, reduce inpatient utilization, reduce emergency services, reduce contact with the criminal justice system, increase employment, attain higher levels of education, and secure preferred housing.

C. Components of PROS

PROS programs offer combinations of the following four service components:

i. *Community Rehabilitation and Support (CRS)*: includes services designed to engage and assist individuals in managing their illness and restoring those skills and supports necessary for living successfully in the community.

ii. *Intensive Rehabilitation (IR)* consists of four different services:
   a. Intensive Rehabilitation Goal Acquisition to help an individual attain a specific goal within a certain area such as education, housing or employment.
   b. Intensive Relapse Prevention includes targeted interventions to reduce the risk of hospitalization or involvement in the criminal justice system.

   IR also includes two evidence-based practices:
   c. Family Psychoeducation
   d. Integrated Dual Disorder Treatment (IDDT) (includes smoking cessation)

iii. *Ongoing Rehabilitation and Support (ORS)*: ORS, as a service, provides supports to assist individuals in managing their symptoms in the competitive workplace. OMH recommends that PROS programs use the Individual Placement & Support evidence-based model for employment services.

iv. *Clinical Treatment*: an optional component of a PROS program, Clinical Treatment provides a recovery-focused, disability management approach with medication management, health assessment, clinical counseling and therapy, symptom monitoring, and treatment for co-occurring disorders. PROS participants can choose to receive their Clinical Treatment through PROS program or from another provider. As of 2015, 87 of the 90 NYS PROS programs offer the Clinical Treatment component and 78% of PROS recipients receive their clinical treatment at their PROS program.

D. Phases of PROS

PROS services are offered in 3 phases that are defined based upon the pace of service planning and the specific service components offered: *Pre-Admission, Admission, and Active Rehabilitation*. NYS issued guidance for authorization and review requirements for each of the 3 phases, detailed in Section V.1. A person-centered approach is key when applying level of care criteria for PROS. The three phases of PROS include:

i. *Pre-Admission*: This phase begins with the initial visit and ends when the PROS provider submits an Initial Service Recommendation (ISR) to the MCO. PROS providers bill a monthly Pre-Admission rate but add-ons for Intensive Rehabilitation, Ongoing Rehabilitation and Supports, and Clinical Treatment are not allowed. The Pre-Admission phase is open-ended to allow flexibility for recipients who may be ambivalent about participation or who may need an extended period of time to develop an initial goal. Although there is no time limit, PROS providers may not bill the Pre-Admission rate for more than two consecutive months. For example, a PROS provider may bill for month A but not month B because the recipient did not participate in month B. If the recipient returns and receives Pre-Admission services in months C and D, the PROS provider may bill for months C and D but may not bill for month E. If the recipient still has not decided to enroll and the provider has not submitted an Initial Service Recommendation, the recipient can remain in Pre-Admission status and the PROS provider could bill for month F and G (but not month H) if the recipient attends the program, etc.

ii. *Admission* begins when the ISR is approved by the MCO. Upon admission, providers may offer additional services and bill add-on rates accordingly for:
    a. Intensive Rehabilitation (IR);
    b. Ongoing Rehabilitation and Supports (ORS); or
    c. Clinical Treatment.

    Prior authorization for the Admission phase will ensure that individuals are not receiving duplicate services from other clinical or BH HCBS providers. An Individualized Recovery Plan (IRP) must be developed within 60 days of the admission date.

iii. *Active Rehabilitation* begins when the IRP is approved by MCO. Concurrent review and authorizations should occur at three-month intervals for IR and ORS services and at six-month intervals for Base/ Community Rehabilitation and Support (CRS) and Clinic Treatment services.

E. Utilization Management for PROS

Prior and concurrent review authorization are required for PROS. OMH requires the following schedule of assessments and care planning for PROS recipients under the NYS Medicaid Fee for Service program:

i. Individualized Recovery Plan (IRP) is developed within 60 days of admission
ii. The IRP is reviewed and updated, at a minimum, every six months
iii. For individuals receiving Intensive Rehabilitation (IR) or Ongoing Rehabilitation and Supports (ORS), the IR or ORS services identified in the IRP shall be assessed for continued need, at a minimum, every three months

The following table lists the admission, continuing stay, and discharge criteria used in the NYS Medicaid Fee for Service program. MCOs should consult these guidelines and incorporate a person-centered approach to develop specific PROS level of care criteria.

PROS Guidelines on Admission, Continuing Stay, and Discharge

Admission Guidelines	Continuing Stay Guidelines	Discharge Guidelines

• To be eligible for PROS admission, a person must:
  ○ Be 18 years of age or older;
  ○ Have a designated mental illness diagnosis;
  ○ Have a functional disability due to the severity and duration of mental illness; and
  ○ Be recommended for admission by a Licensed Practitioner of the Healing Arts.
• Pre-Admission begins with initial visit and ends when Initial Service Plan (ISR) is submitted to the MCO.
• Admission begins when ISR is approved by the MCO. IRP must be developed within 60 days of admission date.
• Active Rehabilitation begins when the IRP is approved by the MCO.
	• Concurrent review and authorizations should occur at 3-month intervals for IR and ORS services and at 6-month intervals for Community Rehabilitation and Support (CRS) and Clinic Treatment services. Continuing stay criteria may include:
	  ○ The member has an active recovery goal and shows progress toward achieving it; OR
	  ○ The member has met and is sustaining a recovery goal, but would like to pursue a new goal; OR
	  ○ The member requires a PROS level of care in order to maintain psychiatric stability and there is not a less restrictive level of care that is appropriate; OR without PROS services the individual would require a higher level of care.
		• Any one of the following must be met:
		  ○ The member has sustained recovery goals for 6-12 months and a lower level of care is clinically indicated.
		  ○ The member has achieved current recovery goals and can identify no other goals that would require additional PROS services.
		  ○ The member is not participating in a recovery plan, is not making progress toward any goals, extensive engagement efforts have been exhausted, and no significant benefit is expected from continued participation.
		  ○ The member can live, learn, work and socialize in the community with supports from natural and/or community resources.

F. PROS and BH Home and Community Based Services

PROS is a comprehensive program that integrates clinical treatment and rehabilitation services, whereas BH HCBS include a menu of specific services that individuals choose to support their recovery in a person-centered manner. Individuals receiving PROS services will not be eligible to receive most BH HCBS because PROS services are meant to address core recovery and rehabilitation needs.

G. Service Delivery and Staffing Composition

PROS is funded under the Rehabilitation Option, as such there is flexibility in delivering services and most PROS services can be delivered in the community. As PROS is a rehabilitation program, staffing can be comprised of a larger percentage of paraprofessionals and peers compared to other program models. The PROS regulations [14NYCRR. §.512.7 (d)] provide essential information about staffing ratios, staffing credentials, staff training, and recipient employees. The clinical treatment component of PROS includes psychiatrist and nursing staff.

H. Additional resources

- Person-centered planning practice and resources:

https://www.omh.ny.gov/omhweb/pros/Person_Centered_Workbook

- Co-enrollment restrictions: guidance related to co-enrollment in PROS and other OMH licensed programs (ACT, CDT, etc.) available at: http://www.omh.ny.gov/omhweb/pros/finance/finance.pdf

3. ACT Utilization Management

A. Introduction

Assertive Community Treatment (ACT) is one of the specialty behavioral health services that will be covered under the expansion of the Medicaid Managed Care benefit package. MCOs operating in New York City will assume management of this service in the adult Medicaid Managed Care Program beginning October 1, 2015. MCOs operating in other counties will begin managing specialty behavioral health services including ACT according to the previously established NYS timeline for integrated managed care.

B. What is Assertive Community Treatment?

ACT teams deliver comprehensive services to individuals with serious mental illness whose needs have not been met by traditional service delivery approaches. ACT is an evidence-based practice that incorporates treatment, rehabilitation, case management, and support services delivered by a mobile, multi-disciplinary mental health team. ACT supports recipient recovery through an individualized approach that provides recipients with the tools to obtain and maintain housing, employment, relationships and relief from symptoms and medication side effects. The nature and intensity of ACT services are developed through a person-centered service planning process and adjusted as needed in daily ACT team meetings.

Typically, ACT recipients have a serious and persistent psychiatric disorder and a treatment history that has been characterized by frequent use of psychiatric hospitalization and emergency rooms, involvement with the criminal justice system, alcohol/substance abuse, and lack of engagement in traditional outpatient services. ACT is especially beneficial for the high-need individuals who require complex, multi-faceted care. The population served by ACT comprises a small subset of individuals with serious mental illness. Most people will not need the intensive services offered by ACT programs.

The ACT program is an intensive service with limited capacity. ACT should be utilized appropriately as a specific service within the larger continuum of care. As HARPs begin to manage BH HCBS, these and other behavioral health services will help transition individuals from ACT teams to appropriate levels of care, creating access for other individuals who need ACT services. The ACT Institute, in partnership with the OMH, provides supports and training to ACT teams with emphasis on a transitional model of care.

C. Referral to ACT

As of June 2015 there are 80 licensed ACT teams serving approximately 5,000 individuals throughout NYS. Due to the limited availability for ACT services, OMH regulations require all referrals be reviewed and assigned by a county single point of access (SPOA) entity under contract to the LGU; DOHMH in NYC. The SPOA process allows ACT slots to be accessed by Medicaid Managed Care enrollees and also by Fee for Service Medicaid recipients and individuals not eligible for Medicaid. Providers and MCOs must work with SPOA to facilitate referrals. In NYC, MCO members should be referred for ACT services as follows:

i. The referring provider (e.g., hospital provider, HH care manager, or other behavioral health provider) contacts MCO to request ACT referral. Provider and MCO care manager review whether the member meets ACT level of care admission criteria. MCO notifies the referring provider of level of care determination within 24 hours.

ii. If the MCO does not approve ACT level of care, MCO works with the referring provider to develop an alternate service plan to meet the member's clinical, rehabilitation, and recovery needs. The referring provider has appeal options as described in the Medicaid Managed Care Model contract.
iii. If the MCO approves ACT level of care, the MCO provides the referring provider with list of in-network ACT teams.
iv. The referring provider submits ACT application with notice of MCO level of care authorization and list of in-network ACT teams to SPOA, which will:
    a. Confirm the member is eligible for ACT; and
    b. Determine the urgency of the member's need for ACT services relative to other applicants.
v. If SPOA disagrees with the MCO approval of ACT level of care, the SPOA care manager will contact the MCO care manager to review the application and arrive at a consensus. If a consensus cannot be reached, the MCO's decision regarding authorization of ACT services will be final. Individuals have the right to appeal such denials as per existing NYS Medicaid Managed Care Program regulations.
vi. If SPOA agrees that ACT level of care is indicated, SPOA will process a complete referral from the point of receipt of a complete application to the point of assignment to an ACT team or placement on a wait list for ACT. In NYC, this process will be completed within 1 business day.
vii. When the member is assigned to a wait list, SPOA will communicate with the referring provider, MCO, and other providers (e.g., HH care manager) as needed to ensure adequate care coordination.
viii. SPOA will attempt to assign members to an in-network ACT team on the list submitted with the application. If the first available appropriate ACT slot is with an out-of-network provider, SPOA will assign to the available ACT team and the MCO will execute an out-of-network agreement. If an out-of-network ACT team refuses to contract with the MCO, SPOA will assign to the next available ACT team.
ix. The accepting ACT team will contact the MCO within 7 days prior to the date of admission to confirm the prior authorization and determine a timeframe for concurrent review.
x. The MCO will notify the local SPOA when the individual is discharged from an ACT program.

Guidance for the Rest of State will be forthcoming.

D. Utilization Management for ACT

NYS guidance to the MCOs regarding prior and concurrent review authorization for ambulatory services is detailed in Section V.1. As noted in the guidance, prior and concurrent review authorization is required for ACT. OMH requires the following schedule of assessments and care planning for ACT recipients under the NYS Medicaid Fee for Service program:

i. Immediate needs assessment should be completed within 7 days of admission
ii. Initial Comprehensive Service Plan should be completed within 30 days of admission
iii. Comprehensive Service Plan reviewed and revised as indicated every 6 months

The table on the following page provides broad guidelines regarding ACT admission, continuing stay, and discharge criteria. MCOs should consult these guidelines and incorporate a person-centered approach to develop specific ACT level of care criteria. OMH will support MCO concurrent review efforts to identify individuals receiving ACT services who demonstrate, over a period of time, an ability to function in major life roles and who can be effectively served with less intensive services. The NYS Health Home program and BH HCBS being added to the HARP benefit package offer new options for enhanced care management and supports to facilitate transition of individuals from ACT teams to other community-based

services. This will help achieve an important system-wide goal to shorten ACT length of stay and improve access to ACT for high-need, high-risk individuals.

July 8, 2015 ACT Guidelines on Admission, Continuing Stay, and Discharge

Admission Guidelines	Continuing Stay Guidelines	Discharge Guidelines
• Severe and persistent mental illness listed in the diagnostic nomenclature (current diagnosis per DSM IV) that seriously impairs their functioning in the community. Priority is given to people with schizophrenia, other psychotic disorders (e.g., schizoaffective disorder), bipolar disorder and/or major or chronic depression, because these illnesses more often cause long-term psychiatric disability. • Priority is also given to individuals with continuous high service needs that are not being met in more traditional service settings • AOT individuals with ACT in their order will get admission priority • Recipients with serious functional impairments should demonstrate at least one of the following conditions: ○ Inability to consistently perform practical daily living tasks required for basic adult functioning in the community without significant support or assistance from others such as friends, family or relatives. ○ Inability to be consistently employed at a self-sustaining level or inability to consistently carry out the homemaker role. ○ Inability to maintain a safe living situation (e.g., repeated evictions or loss of housing). • Recipients with continuous high service needs should demonstrate one or more of the following conditions: ○ Inability to participate or succeed in traditional, office-based services or case management. ○ High use of acute psychiatric hospitals (two hospitalizations within one year, or one hospitalization of 60 days or more within one year). ○ High use of psychiatric emergency or crisis services.	• Initial authorization criteria continue to be met. • An immediate needs assessment and documentation of a plan to address these immediate needs is completed within 7 days of receipt of a referral. • A Comprehensive Assessment is completed within 30 days of admission, with specific objectives and planned services to achieve recovery goals. • The comprehensive service plan is reviewed and updated at least every 6 months which includes status of progress towards set goals, adjustment of goals and treatment plan if no progress is evident. • There is evidence of coordination of care with other providers/stakeholders such as PCPs, specialty providers, inpatient treatment team, AOT, community supports, family, etc. • When clinically indicated psychopharmacological	• ACT recipients meeting any of the following criteria may be discharged: ○ Individuals who demonstrate, over a period of time, an ability to function in major life roles (i.e., work, social, self-care) and can continue to succeed with less intensive service. ○ Individuals who move outside the geographic area of the ACT team's responsibility. The ACT team must arrange for transfer of mental health service responsibility to an appropriate provider and maintain contact with the recipient until the provider and the recipient are engaged in this new service arrangement. ○ Individuals who need a medical nursing home placement, as determined by a physician. ○ Individuals who are hospitalized or locally incarcerated for three months or longer. However, an appropriate provision must be made for these individuals to return to the ACT program upon their release from the hospital or jail. ○ Individuals who request discharge, despite the team's best, repeated efforts to engage them in service planning. Special care must be taken in this situation to arrange alternative treatment when the recipient has a

○ Persistent severe major symptoms (e.g., affective, psychotic, suicidal or significant impulse control issues). ○ Co-existing substance abuse disorder (duration greater than 6 months). ○ Current high risk or recent history of criminal justice involvement. ○ Court ordered pursuant to participate in Assisted Outpatient Treatment. ○ Inability to meet basic survival needs or homeless or at imminent risk of becoming homeless. ○ Residing in an inpatient bed or in a supervised community residence, but clinically assessed to be able to live in a more independent setting if intensive community services are provided. ○ Currently living independently but clinically assessed to be at immediate risk of requiring a more restrictive living situation (e.g., community residence or psychiatric hospital) without intensive community services. • Exclusion criteria: Individuals with a primary diagnosis of a personality disorder(s), substance abuse disorder or mental retardation are not appropriate for ACT	intervention has been evaluated/instituted.	history of suicide, assault or forensic involvement. ○ Individuals who are lost to follow-up for a period of greater than 3 months after persistent efforts to locate them, including following all local policies and procedures related to reporting individuals as "missing persons." • For all persons discharged from ACT to another service provider within the team's primary service area or county, there is a three-month transfer period during which recipients who do not adjust well to their new program may voluntarily return to the ACT program. During this period, the ACT team is expected to maintain contact with the new provider, to support the new provider's role in the recipient's recovery and illness management goals. • The decision not to take medication is not a sufficient reason for discharging an individual from an ACT program. • If a recipient of ACT services is under a court order to receive Assisted Outpatient Treatment, any discharge must be planned in coordination with the County's AOT program administrator.

E. ACT and Health Homes

Many individuals receiving ACT services are also eligible for Health Homes and HH enrollment is strongly encouraged. However, the ACT bundled rate includes care coordination services and MCOs will not pay for HH care coordination while an ACT recipient is enrolled in a HH. Guidance outlining procedures for ACT teams and HHs related to sharing care coordination payments will be forthcoming.

All HARP enrollees must receive a BH HCBS Eligibility Assessment upon enrollment in the HARP and annually thereafter. The HH care manager will complete these assessments for the majority of HARP enrollees. However, if an individual is receiving ACT services when enrolled in a HARP, the ACT team will assume responsibility for the BH HCBS Eligibility Assessment process for as long as the individual is receiving ACT services as described below:

i. If an individual is receiving ACT services when he/she first enrolls in a HARP, the ACT team will assume the HH care management responsibilities. This means the ACT team will be responsible for completing the BH HCBS Eligibility Assessment, which must be completed for all HARP members upon enrollment in the HARP and at least annually thereafter.
ii. If the Eligibility Assessment determines that the individual is eligible for BH HCBS, but the individual is going to continue to receive ACT services, the Full BH HCBS Assessment will not be completed for as long as the individual is receiving ACT services. Individuals receiving ACT services are not eligible to receive most BH HCBS (ACT recipients can receive short-term crisis respite, intensive crisis respite, and non-medical transportation services) but still must complete the initial and annual BH HCBS Eligibility Assessments because:
    a. The assessment information should be used to support care planning; and
    b. The assessment also elicits information required for the NYS MCO performance measurement program.
iii. When a HARP enrollee is being discharged from an ACT service, the ACT team care manager will review the latest BH HCBS Eligibility Assessment. If the individual's circumstances and/or clinical status have changed substantially, the ACT team care manager will repeat the BH HCBS Eligibility Assessment. Using either the new or prior BH HCBS Eligibility Assessment (which always must have been completed within the prior 12 months), the ACT care manager will determine whether the individual meets the BH HCBS eligibility criteria and if so, the ACT team care manager will complete the BH HCBS Full Assessment and develop a BH HCBS plan of care to supplement the ACT discharge plan.
iv. Prior to discharge, the ACT team will ensure the individual is assigned a Health Home care manager or document a declination of service.
v. The BH HCBS plan of care along with the ACT discharge plan will be forwarded to the Health Home care manager as part of a "warm hand-off". The Health Home care manager will assume care management and BH HCBS plan of care responsibilities at that time.

Assessments are billed separately from the care management rate whether they are performed by the Health Home or the ACT Team.

F. ACT and Assisted Outpatient Treatment (AOT)

AOT individuals with ACT included in their court ordered treatment plan will receive admission priority with the local SPOA. Individuals on ACT Teams with active AOT court orders are not eligible for the Health Home Plus (HH+) billing rate as care coordination is included in the bundled rate for ACT services.

G. ACT and PROS

PROS programs integrate treatment, support, and rehabilitation to facilitate individualized recovery. Many individuals may be able to transition from ACT to a PROS program as their community functioning and wellness management skills improve. To facilitate these transitions, NYS regulations allow for individuals receiving ACT services to simultaneously enroll in a PROS program with the following stipulations:

- An individual receiving ACT services may enroll in a PROS program for no more than three months within any 12-month period
- Reimbursement for ACT services provided to individuals who are receiving both ACT and PROS services will be limited to the ACT partial step-down payment rate

H. ACT Institute

The ACT Institute, part of the Center for Practice Innovations (CPI), provides training, support, and consultation to ACT providers across New York State. The training curriculum is based on national evidence-based practice consortium standards and modifications to these standards as developed by OMH. Training is delivered via in-person and distance-learning modalities. See link in ACT Resources for more information.

I. ACT resources

Additional resources and recommended reading:

- NYS OMH ACT Program Guidelines
- ACT Certification Manual
- ACT Regulations
- Assertive Community Treatment Program (ACT) Joining Health Home (HH) Networks
- ACT Providing Health Home Care Management Interim Instruction
- ACT Institute

4. BH HCBS Utilization Management

BH HCBS provide opportunities for Medicaid recipients with mental illness and/or Substance Use Disorders (SUD) who are enrolled in a HARP or HIV SNP to receive services in their own home or community. Implementation of BH HCBS will help to create an environment where the HARP or HIV SNP, Health Home care managers, service providers, enrollees and their chosen supporters/caregivers, and government partners help enrollees prevent, manage, and ameliorate chronic health conditions and recover from serious mental illness and SUD.

These review guidelines provide a framework for discussion between BH HCBS providers and HARPs or HIV SNPs. The review process is a collaboration between all pertinent participants including but not limited to the Health Home care manager, BH HCBS provider, HARP or HIV SNP, and enrollee to review progress and identify barriers or challenges that may be interfering with a reasonable expectation of progress towards the enrollee's chosen goals. These conversations will focus on the enrollee's needs, strengths, and history in determining the best and most appropriate fit of services. These review guidelines are applied to determine appropriate care for all enrollees. In general, services will be authorized if they meet the specific criteria for a particular service. The individual's needs, choice, and characteristics of the local service delivery system and social supports are also taken into consideration.

BH HCBS eligibility will be determined using a standard needs assessment tool, typically administered by the individual's Health Home care manager. Provision of BH HCBS requires a person-centered approach to care planning, service authorizations, and service delivery. HARP and HIV SNP utilization management for BH HCBS must conform to guidelines in the NYS BH HCBS Provider Manual. This manual outlines how BH HCBS care planning and utilization management emphasizes attention to enrollee strengths, goals and preferences, and also ensures enrollee choice of service options and providers. The figures on the following pages outline the process for assessment, development, and authorization of the plan of

care which includes specific BH HCBS for both individuals enrolled in Health Homes and individuals who are not enrolled in Health Homes.

HARP ELIGIBLE ON DOH LIST
ALREADY ENROLLED IN A HARP/HIV SNP PLAN & HEALTH HOME

A
HH Care Manager Conducts HCBS eligibility assessment[1] If eligible, HH Care Manager conducts Full HCBS assessment[2]

B
In collaboration with member, and in consultation with providers as necessary, HH Care Manager develops fully integrated Plan of Care (POC) that includes physical and behavioral health services, and recommended HCBS including the scope, duration, and frequency of HCBS; and Selected In-Network Providers[3]

Note: CPST and Psychosocial Rehabilitation require licensed practitioner order for scope, duration, and frequency of these services for POC

HH care manager consults with CPST and Psychosocial Rehabilitation Provider(s) and when necessary other HCBS providers who recommend scope, duration, and frequency for HCBS. HH care manager completes POC.

C
HH Care Manager forwards fully integrated POC to MCO for approval of all physical health services, behavioral health services, and HCBS in the fully integrated Plan of Care(POC). MCO works collaboratively with HH care manager and member to finalize an approved Plan of Care

D
HH care manager ensures member is referred to services listed in POC

E
HH care manager monitors POC; ensures that member is getting HCBS reflected in POC; revises POC when necessary incorporating member input and choice. When POC revised MCO review is required, loop to box C

[1] The Eligibility Assessment can be done telephonically or face-to-face

[2] The HCBS full assessment must be done face to face. Eligibility and Full Assessments can be done in one face-to-face meeting if desired

[3] POCs that include recommended Home & Community Based Services (HCBS) must meet Centers for Medicare & Medicaid requirements and will include scope, duration and frequency of HCBS; members must be given a choice of at least 2 HCBS providers from the MCO's network and there must be documentation in the POC that choice was given to the member

Key:

- **HCBS Eligibility Assessment**= subset of questions from NYS Community Mental Health Assessment and other HCBS eligibility questions
- **Full Assessment**= NYS Community Mental Health Assessment to help determine array of HCBS

HARP ELIGIBLE ON DOH LIST
ALREADY ENROLLED IN A HARP/HIV SNP PLAN
& CHOOSES NOT TO ENROLL IN A HEALTH HOME

A

The MCO contracts with a HH or other state-designated entity to complete HCBS assessments and develop Plans of Care (POC) for individuals who choose not to enroll in a Health Home (HH).

Care Manager conducts the HCBS eligibility assessment[1]
If eligible, HH Care Manager conducts HCBS
Full HCBS assessment[2]

B

The MCO also contracts with the HH or other state-designated entity to develop the HCBS Plan of Care (POC).

Note: CPST and Psychosocial Rehabilitation require licensed practitioner order for scope, duration, and frequency of these services for POC

In collaboration with member, care manager consults with CPST and Psychosocial Rehabilitation Provider(s) and when necessary other HCBS providers who recommend scope, duration, and frequency for HCBS. Care manager completes POC.

C

Care Manager forwards HCBS POC to MCO. The MCO approves all physical health services, behavioral health services, and HCBS in the fully integrated POC. MCO is responsible for non-HCBS components of the fully integrated POC and for providing care coordination for the implementation of the individual's full POC, including HCBS.

[1] The Eligibility Assessment can be done telephonically or face-to-face

[2] The HCBS full assessment must be done face to face. Eligibility and Full Assessments can be done in one face-to-face meeting if desired

[3] POCs that include recommended Home & Community Based Services (HCBS) must meet Centers for Medicare & Medicaid requirements and will include scope, duration and frequency of HCBS; members must be given a choice of at least 2 HCBS providers from the MCO's network and there must be documentation in the POC that choice was given to the member

Key:

- **HCBS Eligibility Assessment**= subset of questions from NYS Community Mental Health Assessment and other HCBS eligibility questions
- **Full Assessment**= NYS Community Mental Health Assessment to help determine array of HCBS

BH HCBS Admissions, Continued Stay, and Discharge Criteria

Admission Criteria:	Continued Stay Criteria:	Discharge Criteria:
All of the following criteria must be met: 1. The member must be deemed eligible to receive BH HCBS using the BH HCBS Eligibility Assessment tool. 2. Where the member has been deemed eligible to receive services, a full BH HCBS Assessment has been completed to determine these services are appropriate for that individual. 3. A Plan of Care (POC) has been developed, informed and signed by the member, Health Home care manager, and others responsible for implementation. The POC has been approved by the MCO. 4. The BH HCBS provider develops an Individual Care Plan (ICP) that is informed and signed by the member and BH HCBS provider staff responsible for ISP implementation. 5. The ISP and subsequent service request supports the member's efforts to manage their condition(s) while establishing a purposeful life and sense of membership in a broader community. 6. The member must be willing to receive BH HCBS services as part of their ISP. 7. There is no alternative level of care or co-occurring service that would better address the member's clinical needs as shown in POC and ISP.	All of the following criteria must be met: 1. Member continues to meet admission criteria and an alternative service would not better serve the member. 2. Interventions are timely, need based and consistent with evidence based/best practice and provided by a designated BH HCBS provider. 3. Member is making measureable progress towards a set of clearly defined goals; Or There is evidence that the service plan is modified to address the barriers in treatment progression Or Continuation of services is necessary to maintain progress already achieved and/or prevent deterioration. 4. There is care coordination with physical and behavioral health providers, State, and other community agencies. 5. Family/guardian/caregiver is participating in treatment where appropriate.	Criteria #1, 2, 3, 4, or 5 are suitable; criteria #6 is recommended, but optional: 1. Member no longer meets admission criteria and/or meets criteria for another more appropriate service, either more or less intensive. 2. Member or parent/guardian withdraws consent for treatment. 3. Member does not appear to be participating in the ISP. 4. Member's needs have changed and current services are not meeting these needs. Member's self-identified recovery goals would be better served with an alternate service and/or service level. As a component of the expected discharge alternative services are being explored in collaboration with the member, family members (if applicable), the member's Health Home and BH HCBS provider and MCO. 5. Member's ISP goals have been met. 6. Member's support system is in agreement with the aftercare service plan.

State and federal regulations limit members' access to certain BH HCBS when the member is receiving certain state plan behavioral health services as noted below

NYS Allowable Billing Combinations of OMH/OASAS State Plan Services and BH HCBS								
BH HCBS/State Plan Services	**OMH Clinic/OLP**	**OASAS Clinic**	**OASAS Opioid Treatment Program**	**OMH ACT**	**OMH PROS**	**OMH IPRT/CDT**	**OMH Partial Hospital**	**OASAS Outpatient Rehab**
PSR	**Yes**	**Yes**	**Yes**	**No**	**No**	**No**	**Yes**	**No**
CPST	**No**	**No**	**No**	**No**	**No**	**No**	**Yes**	**No**
Habilitation	**Yes**	**Yes**	**Yes**	**No**	**No**	**No**	**Yes**	**No**
Family Support and Training	**Yes**	**Yes**	**Yes**	**No**	**No**	**Yes**	**Yes**	**Yes**
Education Support Services	**Yes**	**Yes**	**Yes**	**No**	**Yes**	**Yes**	**Yes**	**Yes**
Peer Support Services	**Yes**	**Yes**	**Yes**	**No**	**Yes**	**Yes**	**Yes**	**Yes**
Employment Services	**Yes**	**Yes**	**Yes**	**No**	**No**	**Yes**	**Yes**	**Yes**

5. LOCADTR Policy

The NYS Medicaid Managed Care Model Contract requires that MCOs utilize the OASAS provided LOCADTR tool for making SUD level of care decisions. The tool is accessible through the Health Commerce System (HCS). Each clinical reviewer or care manager utilizing the tool must acquire a user name and password and be assigned LOCADTR access through the MCO's (HCS) manager. The LOCADTR is a web-based tool that utilizes a series of clinical questions to determine individual risk and resources. Following the several logic pathways, answers to the questions lead to an initial LOCADTR recommended level of care. In most cases, this process will result in a level of care both recommended by the provider and approved by the service payer.

A. Prior Authorization and Notification

Providers will be required to complete a LOCADTR prior to admission for every OASAS certified level of care and, with appropriate consents, can share the LOCADTR report with MCOs. For levels of care that require prior authorization[8], the program will share the LOCADTR report and clinical information as requested by the MCO to support the level of care recommendation. Where the MCO and provider believe the LOCADTR leads to a different level of care, the MCO and provider identify the specific question(s) that have led to the difference in recommendation. Using a patient-centered treatment planning philosophy the conversation between the MCO and provider should focus on the MCO member's needs. In most cases, the MCO and provider will agree to the level of care by resolving the difference in how the provider and MCO viewed the question(s) that lead to the difference either through additional information or a discussion of clinical factors.

In the event that the MCO issues an adverse decision, it will identify in writing the specific question in the LOCADTR logic thread that led to the determination. For example:

Based on the information provided, (ABC Plan) has determined you do not need inpatient rehabilitation because you do not meet the criteria for inpatient rehabilitation and your condition may be stabilized on an outpatient basis. Your provider indicated you have (medical complications requiring inpatient rehabilitation program), however no documentation was provided indicating (complications). Based on a review of the clinical information, your needs may be met by an (intensive outpatient level of care). Please speak to your provider about your treatment options

When a level of care does not require prior authorization but does require a notification from the provider, the LOCADTR report will be sent by the provider to meet the reporting requirements and support the decision for the admission. The MCO will review the report and may request additional clinical information from the provider.

B. Concurrent Review

[8] Pursuant to the Medicaid Managed Care Model Contract, the contractor shall not require prior authorization for either urgent or non-urgent ambulatory services delivered by: OASAS certified Part 822 outpatient clinics (including intensive outpatient services); outpatient rehabilitation; opioid treatment programs; and, Part 816 Medically Supervised outpatient withdrawal and stabilization programs.

Providers will be required to complete a LOCADTR whenever an admission or a change in level of care is being considered. Examples include:

i. Individual is not responding in outpatient care, team has recommended that level of care be re-evaluated
ii. Individual is in inpatient care and issues necessitating the referral are resolving. The inpatient program should send the LOCADTR report when discharge is planned and work with the MCO to link the person to the recommended care
iii. The MCO requests a review of the current level of care. This should occur only when clinically reasonable evidence for the request is provided by the MCO in accordance with PHL §4905(6). For example, after an inpatient admission, when the reason for the admission can reasonably be expected to have resolved per patient care plan and the patient's clinical status.

6. Opioid Treatment Policy

Opioid treatment programs serve a vulnerable population of individuals who are prescribed primarily agonist and partial agonist medications for Opioid Substance Use Disorder. The programs provide medical and clinical intervention as well as medication monitoring and administration. This level of care is highly regulated by federal agencies (Substance Abuse and Mental Health Services Administration (SAMHSA), Drug Enforcement Administration (DEA)) and OASAS and is accredited by Commission on Accreditation of Rehabilitation Facilities (CARF) or Joint Commission on Accreditation, Health Care, Certification (JCAHO) to provide care. Agonist treatment has been determined to be safe and effective. OASAS certifies 32 opioid treatment programs in the NYC area and approximately 40,000 individuals on any given day across the state. Despite the overwhelming support for this treatment, there remain misconceptions and stigma towards individuals receiving and providing care. As this modality moves into a Medicaid Managed Care environment, it will provide opportunities for provider and MCO collaboration including opportunities for better integration of care.

A. Utilization Management

Agonist treatment works by satiating dopamine receptors. When the dose is adequate, cravings and urges to use opioids are eliminated and activation of the receptor is blocked eliminating the reward for opioid use. Treatment with an agonist is expected to occur long-term. If the dose is tapered the symptoms of craving and urges to use recur and relapse is likely. The decision to taper should always be a decision that occurs between the patient and the physician or treatment team and should include the patient's full informed consent and understanding of the risks and benefits of the decision.

B. Take-home doses

Opioid treatment programs must comply with the federal and OASAS minimum standards for allowing for take home doses of methadone based on time in treatment and eight clinical markers. Programs should individualize treatment including the number of take home medications allowed based on the regulations, as well as the clinical presentation of the individual. MCOs must have a process for analyzing visit patterns for Opioid treatment programs. Programs treating large numbers of individuals with high numbers of medication visits outside of the allowable take home structure may have a higher than average number of patients with high SUD and co-occurring conditions that require more frequent visits or there may be other reasons that the program is not maximizing individual independence. The MCO may consider targeting outlier clinical patterns of care to encourage clinically appropriate and individualized take home schedules.

C. Plan of care

Agonist treatment with methadone and partial agonist treatment are expected to be long-term interventions. Medication should be individualized since there is no dosage recommendation for specific patient presentations. Dose adequacy is based on how the individual responds to treatment and an effective dose is determined by the elimination of craving and urges to use opioids. Individuals in treatment often require individual, group, and family counseling to build social, emotional, and interpersonal skills. Individuals may have social service, housing, employment, co-occurring chronic medical, or mental health needs which should be identified in the assessment process and included in the plan of care. Continued methadone treatment should not be conditioned on the elimination of other substance use, however, individual care plans should address other substance use.

VI. Finance and Reimbursement

1. Introduction

The inclusion of almost all Medicaid reimbursed services into all Medicaid Managed Care Model Contracts is accompanied by changes to the risk profile of the MCOs and the risk mitigation strategies in which the State will financially participate.

2. Minimum Medical Loss Ratio (MLR) and Risk Corridor [HARPs only]

i. HARPs will be required to expend 89% of net premiums earned, after deducting DOH allowances for taxes and other "pass-throughs", each calendar year, including part years of operation (both expenditures and premiums earned are accounted for on an accrual basis) on physical health, behavioral health services, and prescription drugs. Excluded from services are all care management activities by Health Homes and other designated entities undertaken on behalf of the HARP's enrollees and any other care management activities performed by the HARP that are separately reimbursed, e.g., assessments, on a non-risk basis by NYS. Any MLR under expenditure by any HARP will be recovered by NYS to be reinvested in services for individuals with behavioral health disorders.

The MLR in Years 1 and 2 of HARP operation will EXCLUDE BH HCBS services. The MLR will have to be reconsidered when BH HCBS services are added to the HARP premiums.

ii. Risk Corridor – HARPs only

The net premium for HARPs (see 2.i, above) has the following estimate of expenditures, expressed as a percentage of the total premium:

a. Physical Health and behavioral health services and prescription drugs(services) – 89%
b. Administration
    i. Ongoing annual allowance– 7.5%
    ii. Start-Up allowance– 2% Year 1 (through Dec 2016 in NYC; TBD for ROS); 1% for Year 2; 0% Year 3 and thereafter
c. Underwriting Gain – 1.5% (maximum)
d. Transfer to payment for performance pool – 0% Year 1; 1% Year 2; 2% Year 3 and thereafter
e. NYS will reimburse HARPs for losses they incur for physical and behavioral health services and prescription drugs after the MCOs incur a loss of 1.5% of premiums earned under the following circumstances:
    - The calculation of the State's reimbursement to any HARP will include the following steps:
        - Where the sum of expenditures by any HARP in any contract year for
            - behavioral and physical health services and prescription drugs total more than 89% of net premiums earned, and
            - The lesser of the allowances for continuing and Start-up administrative costs or actual administrative expenses,
        - exceed 101.5% of net premiums earned,
        - the State shall reimburse the HARP 100% of the amount in excess of 101.5% of total premiums earned.

3. Behavioral Health Expenditure Target (BHET) – MMC and HIV SNP

The Governor's Medicaid Redesign Team (MRT) recommendations and subsequent enacted legislation require that the wholesale addition of almost all behavioral health services into Medicaid Managed Care and the creation of HARPs be accompanied by provisions to prevent redeployment of resources historically dedicated to providing behavioral health services to individuals with mental illness and/or Substance Use Disorders to other uses. Both anticipate that having MCOs manage all behavioral health specialty services for all enrollees will likely produce some changes to patterns of service utilization and may reduce overall utilization of some behavioral health services. Both required that any savings in behavioral health services not be profit to the MCOs, but be reinvested into other behavioral health and related services to address unmet needs of the behavioral health population.

MMCs and HIV-SNPs will be held to a BH expenditure target. The requirements for identification of cost reductions in MCO behavioral health expenditures are under development. This section will be updated when these requirements are finalized.

4. Stop Loss - MMC, HIV SNP, and HARP

A. The current Medicaid managed care Stop Loss provisions

i. Mental health and Substance Use Disorder inpatient treatment services are currently covered up to a 30 day combined benefit per enrollee per calendar year for covered psychiatric inpatient services and Title 14 NYCRR Part 818 Substance Use Disorder inpatient rehabilitation treatment services.

ii. Title 14 NYCRR Part 816 hospital inpatient detoxification expenses are currently incorporated into the inpatient hospital stop loss provision.

B. Updated Behavioral Health Inpatient Stop Loss - MMC, HIV SNP, and HARP

Effective January 1, 2016 statewide for all individuals for whom psychiatric inpatient and/or Substance Use Disorder inpatient services are a covered service, the psychiatric inpatient stop loss and Substance Use Disorder inpatient stop loss provisions will change and be updated as discussed below.

i. <u>Psychiatric Inpatient Stop Loss:</u>

Statewide effective January 1, 2016, the stop loss provisions will be per inpatient episode (a change from per enrollee per year). An inpatient episode is defined as duration measured in continuous days in a psychiatric inpatient unit counting from the day of admission to the day of discharge in an OMH licensed psychiatric inpatient unit. Each new admission commences a new episode, without regard to the period between a prior discharge and the next admission. An intra-hospital transfer from a psychiatric inpatient unit to another unit ends the psychiatric episode for the purpose of calculating the stop loss. A subsequent return transfer back to the psychiatric inpatient unit begins a new psychiatric inpatient episode on the day of return. The commencement of State financial reimbursement to MCOs for lengthy episodes changes from Year 1 to Year 3:

- For calendar year 2016, the MCOs will be responsible for 100% of the appropriate payments for the first 45 days of each episode and 50% of the payments for the next 15 days of each episode (i.e., days 46-60 of the episode).The State will reimburse the MCOs the other 50% of the payments for days 46-60 and 100% for all days beyond 60 of any episode of psychiatric inpatient care.
- For calendar year 2017, the MCOs will be 100% responsible for days 1-60 of each episode and 50% for days 61-100. The State will reimburse the MCOs 50% for days 61-100 and 100% for all days beyond 100.
- For calendar year 2018 and thereafter, the MCOs will be 100% responsible for days 1-100 of each episode. The State will reimburse the MCOs 100% for all days beyond 100.

ii. Substance Use Disorder Inpatient Stop Loss:

Statewide effective January 1, 2016 the SUD inpatient stop loss policies will be updated to:

- Remove Title 14 NYCRR Part 818 Substance Use Disorder inpatient expenses from the previous 30 day combined stop loss benefit and include such expenses within the inpatient hospital stop loss provision.
- NOTE: The inpatient hospital stop loss provision will continue to include Title 14 NYCRR Part 816 inpatient detoxification services per current policy.

5. Government Rates

Per the Medicaid Managed Care Model Contract, MCOs must reimburse ambulatory behavioral health providers licensed or certified by OMH or OASAS, including Comprehensive Psychiatric Emergency Programs and the Extended Observation Beds included in these programs and out of network providers, at Medicaid Fee for Service rates for 24 months.

For services delivered by clinics licensed by OMH, such rate will not be subject to the provisions for payment discounting for visits beyond 30 in a year included in 14 NYCRR Part 599.13(e)(2). MMC/HARP/HIV SNP will not impose service authorization requirements prior to the 30th visit paid per calendar year. Multiple procedures, as described in 14 NYCRR Part 599, delivered on one date will count as one visit.

For services delivered in clinics certified by OASAS, such rate will not be subject to the provisions for payment discounting for visits beyond 75 in a year as authorized by sections 26 and 111(a) of part H of chapter 59 of the laws of 2011.

VII. Staffing Requirements

1. Introduction

This guidance applies to the Medicaid Managed Care, HIV SNP, and HARP programs. This guidance contains staffing requirements consistent with the recommendations of the MRT Behavioral Health Stakeholder workgroup as well as staffing requirements detailed in the March 2014 Request for Qualification (RFQ).

Nothing in this guidance is intended to supersede the MCO's required compliance with a staffing plan approved by New York State during the qualification process. In the event of a conflict between the guidance contained herein and a State-approved staffing plan, such staffing plan shall govern.

The staffing requirements outlined here are to ensure MCOs have the required behavioral health, physical health, pharmacy, utilization management, quality management, and care management expertise to meet the needs of individuals with mental illness, Substance Use Disorders (SUD), and co-occurring physical health challenges. In order to meet these needs, the State expects all MCO staff members will work as an integrated team with the State, providers, including Health Homes, and the Regional Planning Consortiums (RPC) regardless of each MCO's organizational structure. The MCO shall also establish and maintain an organizational culture and leadership approach that supports collaboration among stakeholders and embraces New York State's vision of a person-centered, recovery-oriented, outcome-driven, and fully-integrated health and behavioral health care system.

2. Staffing Requirements Overview

The MCO shall recruit, hire, train, supervise and, if necessary, terminate such professional, paraprofessional, and support personnel as necessary to carry out the terms of the contract and meet performance standards contained therein. MCOs shall add additional behavioral health resources as necessary to meet these obligations. All staff shall have the training, education, experience, and credentials, as applicable, to perform assigned job duties.

Table 1 below summarizes the MCO's key staff requirements according to the type of managed care programs the MCO is authorized to operate. Definitions and qualifications of key staff are contained in Section 3. Unless otherwise indicated, key staff positions are not required to be full-time positions; one individual could fulfill multiple roles for the MCO if the individual meets the applicable requirements and if the MCO has obtained State approval for the personnel sharing arrangement. As further explained in Section 3.B, numerous key staff personnel must also be physically located in New York State.

In addition to key staff, the MCO shall also employ a sufficient number of qualified managerial and operational staff to oversee and carry out the MCO's operations relating to the provision of services and support to enrollees with behavioral health needs. Criteria for managerial and operational staff are further detailed below in Section 4.B, "Managerial and Operational Staff Requirements".

Table 1: Key Staff Requirements by Plan Type						
	Mainstream Plan Behavioral Health Medical Director	Mainstream Plan Behavioral Health Clinical Director	HARP Behavioral Health Medical Director	HARP Behavioral Health Clinical Director	HARP Medical Director for General Medicine	HIV SNP Medical Director
MCO Mainstream MC Plan only	X	X				
MCO HIV SNP only	X	X				X
MCO with HARP with 4,000 or more Enrollees	X	X	X (Full-time, dedicated to HARP)	X (Full-time, dedicated to HARP)	X	
MCO with HARP with less than 4,000 Enrollees	X	X	X	X	X	
MCO with HIV SNP and HARP with 4,000 or more Enrollees	X	X	X (must be full-time)	X (must be full-time)	X	X

3. Key Staff Responsibilities and Qualifications

A. Responsibilities of Key Staff

In addition to any other job requirements imposed upon key staff by the MCO, the MCO shall ensure that the key staff described in this section shall be assigned responsibility for the following essential functions, as appropriate to job title:

i. Development, implementation, and interpretation of clinical-medical policies and procedures that are specific to behavioral health or can be expected to impact the health and recovery of behavioral health consumers, including the evaluation of behavioral health medications and other emerging technologies for the treatment of behavioral health conditions.

ii. Ensuring strong collaboration and coordination between physical and behavioral health care within the MCO's entire organization and provider networks.

iii. Clinical peer review recruitment and supervision.
iv. Provider recruitment, education, training, and orientation.
v. Decision-making process for behavioral health provider credentialing decisions.
vi. Behavioral health provider quality profile design and data interpretation.
vii. Development and implementation of the behavioral health components of the Quality and Utilization Management Plans, including having the behavioral health medical director serve as the chairperson of the behavioral health quality committees.
viii. Administration of all behavioral health quality and utilization management and performance improvement-related activities, including grievances and appeals.
ix. Attendance at regular MCO leadership and medical director meetings designated by the State.
x. Attendance at Regional Planning Consortium meetings.

B. Key Staff Qualifications

i. MCO Behavioral Health Medical Director**:** All MCOs shall employ a MCO Behavioral Health Medical Director who shall have overall accountability for behavioral health services for MCO enrollees. This individual shall be a New York State licensed physician and shall have a minimum of five years of experience working in behavioral health managed care settings or behavioral health clinical settings (at least two years must be in a clinical setting). The MCO Behavioral Health Medical Director shall have appropriate training and expertise in general psychiatry and/or addiction disorders (e.g., board certification in general psychiatry and/or certification in addiction medicine or certification in the subspecialty of addiction psychiatry). The individual serving in this position must be located in New York State.

ii. MCO Behavioral Health Clinical Director: All MCOs shall employ a MCO Behavioral Health Clinical Director. This individual shall be a New York State licensed Behavioral Health Professional[9] and have at least seven years of experience in a behavioral health managed care setting or behavioral health clinical setting, including at least two years of managed care experience (preferably Medicaid managed care). This individual must have appropriate managerial experience and be located in New York State.

iii. HARP Behavioral Health Medical Director: MCOs operating a HARP shall employ a full time HARP Medical Director who, in coordination with the HARP Medical Director for General Medicine, shall oversee the integration of behavioral health and physical health, including a focus on pharmacy benefits and health risks of psychotropic drugs. This individual shall be a New York State licensed Physician and shall have a minimum of five years of experience working in behavioral health managed care settings or behavioral health clinical settings (at least two of which are in a clinical setting). The HARP Behavioral Health Medical Director shall have appropriate training and expertise in general psychiatry and/or Substance Use Disorders (e.g., board certification in general psychiatry and certification in addiction medicine or certification in the subspecialty of addiction psychiatry).

[9] A Behavioral Health Professional is an individual with either at least a Master's Degree in the field of mental health or addictions who holds an active, unrestricted license to practice independently or an individual with an Associate's Degree or higher in nursing who is a registered nurse with three years of experience in a mental health or addictions setting.

If the MCO operates a HARP with less than 4,000 Enrollees, this position need not be full-time and the position may be shared between the MCO's MMCP and HARP. In such cases, the individual shall have overall behavioral health accountability for both product lines.

iv. HARP Behavioral Health Clinical Director: MCOs operating a HARP shall employ a full time HARP Behavioral Health Clinical Director. This individual shall be a New York State licensed Behavioral Health Professional with at least seven years of experience in the management of behavioral health services in a behavioral health managed care setting or behavioral health clinical setting, including at least two years of managed care experience (preferably Medicaid managed care) This individual must be located in New York State.

If the MCO operates a HARP with less than 4,000 Enrollees, this position need not be full-time and the position may be shared between the MCO's MMCP and HARP. In such cases, the individual shall have overall behavioral health accountability for both product lines.

v. HARP Medical Director for General Medicine: MCOs operating a HARP shall employ a HARP Medical Director for General Medicine who, in collaboration with the HARP Behavioral Health Medical Director, shall oversee the integration of general medicine with behavioral health services, including a focus on pharmacy benefits and health risks of psychotropic drugs. The HARP Medical Director for General Medicine shall be a New York State licensed physician and should be board certified in general medicine or family practice. MCOs are not required to employ an individual in this position on a full-time basis, but MCOs choosing not to employ an individual in this position on a full-time basis shall provide the State with the percent of time this individual will devote to the MCO's HARP (in terms of full-time Employee [FTE] time) and provide their rational for this allocation.

vi. Key Staff Requirements for HIV SNPs:
MCOs operating HIV SNPs shall retain an MCO Behavioral Health Medical Director and MCO Behavioral Health Clinical Director to manage the provision of behavioral health care for all HIV SNP enrollees, including those who meet HARP eligibility criteria and may be eligible for BH HCBS. These positions do not have to be full-time, but individuals in such positions must be located in New York State. The MCO must also retain an HIV SNP Medical Director who is an HIV Specialist.

MCOs operating an HIV SNP shall ensure that the MCO Behavioral Health Medical Director, MCO Behavioral Health Clinical Director, or the HIV SNP Medical Director possesses the necessary qualifications to carry out all of the responsibilities outlined in Section C (i), such as ensuring strong collaboration and coordination between physical and behavioral health care within the MCO's entire organization.

4. Managerial and Operational Staff Requirements

A. General Requirements

The MCO shall employ managerial and operational personnel sufficient in number to oversee and provide each of the functions listed in Section 3. A, above. To the greatest extent possible, the MCO's managerial and operational staff shall have expertise in providing for the needs of individuals with serious behavioral health conditions. Managerial staff may be shared between the MCO's mainstream product line and HARP,

if appropriate and if such arrangement has been approved during the State qualification process. If the MCO intends to begin sharing managerial staff between product lines after the State has approved the MCO's staffing plan, the MCO shall obtain approval from the State before such staff consolidation or reorganization takes place.

B. Managerial and Operational Staff Requirements

MCO shall ensure managerial and operational staff is assigned responsibilities for the following functions and that such assigned personnel possess the relevant knowledge and experience indicated below:

i. Behavioral health care management:
   a. Managers responsible for oversight of care management must be licensed Behavioral Health Practitioners with experience working in a managed care or behavioral health clinical setting. Experience working with Health Homes is also recommended.
   b. Operational staff must be licensed Behavioral Health Practitioners and shall have experience and expertise in managing care for adults with behavioral health needs.
   c. Operational staff must be available during MCO's normal business hours.
   d. Both managers and operational staff must be located in New York State.

ii. Behavioral health utilization management:
   a. Managers responsible for oversight of behavioral health utilization management must be licensed Behavioral Health Practitioners with experience working in a managed care or behavioral health clinical setting.
   b. Operational staff must be licensed Behavioral Health Practitioners and shall have experience and expertise in managing care for adult with behavioral health needs.
   c. Admission and continued stay authorizations shall only be made by licensed Behavioral Health Practitioners with a minimum of three years of clinical experience in a behavioral health setting.
   d. The MCO shall employ behavioral health clinical peer reviewers to conduct denial and appeal reviews, peer review of psychological testing, or complex case review and other related consultations. Such behavioral health clinical peer reviewers shall be either physicians board certified in adult psychiatry, physicians who hold a Certification in addiction medicine or a Certification in the subspecialty of addiction psychiatry, or licensed doctoral-level psychologists.
   e. Both managers and operational staff must possess knowledge of behavioral health rehabilitation and recovery services.
   f. Utilization Management staff must be available at all times (24 hours a day, 7 days a week) to conduct prior authorization, concurrent, and retrospective review for behavioral health care decisions.

iii. Behavioral health network development:
   a. Managers responsible for oversight of network development shall have experience working in a managed care or behavioral health clinical setting and demonstrated experience in network development for mental health and Substance Use Disorder services.
   b. Managers shall have knowledge of and experience with principles of physical-behavioral health integration and evidence-based practices, including but not limited to wellness self-management,

supported employment, family psychoeducation, Assertive Community Treatment, Assisted Outpatient Treatment, and Integrated Dual Disorder Treatment.

c. Both managers and operational staff must be located in New York State.

iv. Behavioral health provider relations:

a. Managers responsible for oversight of behavioral health provider relations shall have experience working in a managed care or behavioral health clinical setting and experience managing behavioral health provider issues including resolving grievances, coordinating site visits, and maintaining quality of care.

b. Operational behavioral health provider relations staff shall be distributed throughout the City and State of New York in direct proportion to the MCO's provider network in each county comprising the MCO's service area.

c. Both managers and operational staff must be located in New York State.

v. Behavioral health training:

a. Managers and operational staff responsible for developing, tracking, and executing behavioral health training to MCO's own and network provider staff shall have significant experience and expertise in developing training programs related to behavioral health systems.

b. Familiar with recovery-oriented services.

vi. Behavioral health quality management:

a. Managers and operational staff responsible for behavioral health quality management shall possess experience and expertise in quality improvement for mental health and Substance Use Disorder services programs, ideally in publically-operated or publically-funded programs.

b. Experience with managed care delivery systems.

c. Familiar with recovery-oriented services.

vii. Behavioral health information systems:

a. Managers responsible for the development and oversight of MCO's information systems shall have significant experience and expertise in Medicaid data analytics and behavioral health data systems.

b. Knowledge of all federal and state laws governing the confidentiality and security of protected health information, including confidential mental health and Substance Use Disorder information.

viii. Government/community relations:

a. MCO must designate representative(s) to attend relevant stakeholder, planning, and advocacy meetings to ensure that the MCO is aligned with New York State's vision for managed delivery of behavioral health services and is aware of any new State or local behavioral health initiatives.

b. Representatives must be located in New York State.

C. Additional staffing requirements for HARP and HIV SNP

The MCO shall employ qualified managerial and operational staff dedicated to HARP specific benefits, including HARP care coordination and BH HCBS. Managers overseeing the provision of HARP specific

benefits shall be familiar with both behavioral health rehabilitative services and regulatory requirements related to the provision of BH HCBS.

5. State Notification Requirement in Event of Qualifying Staffing Reduction

For HARPs and HIV SNP Plans Only: The MCO shall not reduce staffing levels by more than 10% from the staffing levels approved by the State during the behavioral health qualification process without prior approval from DOH, OMH and OASAS. The MCO shall provide written notice to the State at the earliest practicable time, or at a minimum, seven days before such qualifying staff reduction becomes effective. Such notice shall include the reasons for the staff reduction, a transition plan for how the MCO will meet its contractual obligations with retained staff, and a restoration plan for recruiting and hiring qualified staff to restore staffing levels to State-approved levels.

For all MCOs product lines: The MCO shall provide written notice to the State within seven calendar days after the effective date of termination or resignation of any of the key staff listed in Section 3. B above, including the name of the interim contact person performing the key staff person's duties, if a replacement is not found within that time. In addition to the notice of termination or resignation, the MCO shall submit a written proposal for replacing the key staff person, including expected timelines for recruitment activities. The MCO shall also notify the State at the earliest practicable time, but in no event later than seven days if a key staff member who is required to be full-time drops below full-time status. The State reserves the right to review the qualifications of key staff replacements at any time and require the MCO to identify a different key staff person if their replacement does not meet the requirements set forth in this guidance.

6. Other Staffing Requirements

The MCO shall maintain current organizational charts and written job descriptions for each functional area consistent in format and style.

The MCO shall develop and maintain a human resources and staffing plan that describes how the MCO shall maintain adequate staffing levels and conduct staff training required by the contract between the MCO and the State.

Where the MCO is permitted to employ individuals outside of New York State to perform required functions, the MCO shall ensure such employees receive sufficient training on New York State's Medicaid program and covered services, with a specific emphasis on OMH and OASAS behavioral health programs, BH HCBS, and Health Homes, if applicable.

VIII. Regional Planning Consortiums (RPC)

1. Background

In preparation for both the opportunities and challenges the expansion of behavioral health services in Medicaid Managed Care will present at the local level, the state and the counties/New York City collaborated to develop 11 Regional Planning Consortiums throughout the State where key stakeholders can discuss and monitor issues inherent to this type of transition. Each RPC represents natural local patterns of access to care and include representatives from LGUs, the State, mental health, SUD, and primary care service providers, the child welfare/criminal and or juvenile justice/housing/social service systems, Health Homes, hospitals and MCOs, as well as Medicaid recipients and behavioral health service recipients, peers, families, and advocates.

The RPCs are a necessary mechanism for the State and the MCOs to obtain vital, real-time feedback and recommendations for improving the implementation of behavioral health managed care. In addition, the RPC in each region will help align Medicaid managed behavioral healthcare with other system redesign initiatives aimed at improving the quality and integration of the physical and behavioral healthcare delivery systems, as well as strategize ways to use potential future reinvestment funding. To that end, the RPCs should complement the existing work of their respective and participating LGUs in guiding behavioral health policy as it relates to Medicaid Managed Care in each region.

This document further outlines the specific role and function of all RPCs, in relation to the MCOs, and describes where the New York City RPC (NYC RPC) and the remaining ten New York State RPCs henceforth referred to as the Rest of State RPCs (ROS RPCs), diverge in structure and scope, as relevant to MCO planning and participation.

2. Scope and Function

A. The core focus areas within the scope of RPC function are

i. Service access and capacity: monitoring the timely access to services, including BH HCBS, for Medicaid recipients of behavioral healthcare, as well as service gaps.
ii. MCO performance: observing MCO actions with respect to their responsibilities to behavioral health service recipients and providers of Medicaid services.
iii. System stability & improvement: facilitate collaboration among any and all regional sectors that touch the Medicaid behavioral health system.
iv. Service quality, efficiency, and efficacy: improving care of behavioral health service recipients overall by voicing concerns as they arise and making recommendations to State Partner Agencies (DOH, OMH, and OASAS).

B. All New York State RPCs will share three primary functions

i. To be the early warning system for locally occurring issues which data would not immediately or necessarily show (such as access to needed services, gaps in services, timeliness of eligibility determinations, and engagement or disengagement in care, etc.); and for ongoing monitoring, deliberation, and forming recommendations to the State in response to issues that arise from stakeholders at the table:
    a. Members will be expected to give status updates from the field, especially regarding payment and billing; data needs and Informational Technology (IT); and training and education. Based on issue analyses, the RPC will recommend next steps to the State, which may include:

- Identifying systemic and contract related issues, either between the State and the MCOs or the MCOs and service providers, to State partners and recommendations for improvement.
- Convening topic or issue based meetings with MCOs, including HARPs, MMCPs, and HIV SNPs, to address issues at the MCO and local level.
- Establishing and participating in workgroups to address local systems issues in collaboration with the MCOs and State partners.

b. RPC will make any request for data related to the MCO's performance to the State partners. Such data might include:
   - Payment and billing
   - Data and IT needs
   - Training and education

ii. To understand and improve the parallel process and intersection of the expansion of behavioral health services under Medicaid Managed Care with other system redesign initiatives, especially the Delivery System Reform Incentive Payment (DSRIP) Program and Population Health Improvement Program (PHIP):
   a. All RPCs will include representatives from the DSRIP Performing Provider Systems (PPSs). The RPC, together with the LGU (or in the case of NYC, the NYC RPC), will help create as much continuity and efficiency as possible across multiple MCOs and PPS projects serving the counties and the regions.
      ROS RPCs will address downsizing and closure of State psychiatric centers.

iii. To work with their respective LGUs, which are the points of accountability for MCOs in identifying and addressing local system issues:
   a. In the case of the NYC RPC, the DOHMH will function both as both the LGU and RPC convener. DOHMH will systematically analyze problems identified through the RPC, data reviews, and feedback from other stakeholders, and provide appropriate recommendations to the State via the Quality Steering Committee[10] (QSC).
   b. In the ROS RPCs, the LGUs in each region will participate on the RPC. The ROS RPC shall be the primary point of interaction between the LGUs and the MCOs.

3. Structure

A. NYC RPC

i. There will be two co-chairs chosen by the RPC Advisory Board. One of the co-chairs will be a representative of DOHMH.

ii. The Advisory Board will be comprised of multiple-stakeholders who will review the work, recommendations, and requests of Steering Groups, and be comprised of the co-chairs of those Steering Groups.
   a. Stakeholder groups will include MCOs, providers, behavioral health service recipients, families, local social service and related agencies, and other advocates.
   b. The State shall have an ex-officio role on the advisory committee.

[10] Quality Steering Committee (QSC) means a committee comprised of representatives from DOH, OMH, OASAS, and the DOHMH, to coordinate the monitoring and oversight of the quality of Behavioral Health in MMCPs serving residents of New York City.

iii. Steering Groups will provide the main opportunity for key stakeholder communities to deliberate and come to consensus opinion about key issues, solutions, or recommendations they wish to forward to one another, and/or to DOHMH, to engage.

B. ROS RPCs

i. ROS RPCs are based on multi-stakeholder, regional membership operating under a Collaborative Governance with Consensus Decision Making model. ROS RPCs include:
    a. Board of Directors
    b. Two Board Co-Chairs
    c. Committee Chairs
    d. Standing Committees (Children and Families committee is mandatory)
    e. Ad Hoc Committees

ii. The RPC will be comprised of multiple-stakeholders who will review the work, recommendations, and requests of Standing and Ad Hoc Committees.
    a. Stakeholder groups will include MCOs, providers, behavioral health service recipients, families, local social service and related agencies, and other advocates.
    b. The State shall have an ex-officio role on the RPC.

4. Policy

This section outlines the MCO's role and responsibility with respect to RPC participation statewide.

A. MCO performance

i. The MCO shall participate in the RPC planning process. At a minimum, the plan's Behavioral Health Medical Director, Behavioral Health Clinical Director, and Government/Community Liaison must participate on/with the RPCs.

ii. The MCO shall participate in addressing/responding to issues brought to their attention by the State which have been identified through the RPC. Examples of these issues include but are not limited to: timeliness of payment actions/claims denials, eligibility determinations for services, medical necessity determinations, access to needed services, enrollment, utilization review, Health Home engagement and assessment.

B. Access and capacity

i. Network Adequacy: The MCO shall seek input from the RPC as a part of its efforts to analyze its behavioral health network and shall submit to the State an annual Behavioral Health Network Plan to address unmet enrollee behavioral health service needs in accordance with the State-issued Behavioral Health Guidance.

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

C. System Stability

i. Through participation in the RPC, the MCO will assist the State and LGUs in addressing region-specific issues arising from the changing role of the MCO within the social service systems impacted by the transition to Medicaid managed behavioral healthcare.

D. Service efficiency, efficacy and quality

i. Provider training and education: The MCO shall coordinate with the RPCs and the State to develop and implement a comprehensive provider training and support program for behavioral health network providers to gain appropriate knowledge, skills, and expertise, and receive technical assistance to operate and provide quality behavioral health care within a managed care payer system, in accordance with State-issued "Guidelines for Behavioral Health Network Adequacy."

ii. Quality Assurance Program and Quality Monitoring: The MCO shall develop and maintain mechanisms to monitor service quality and develop quality improvement initiatives and solicit feedback and recommendations from key stakeholders to improve quality of care and member outcomes. These mechanisms will include the input and participation of the RPC in each region.

iii. Memorandum of Agreement (MOA) with RPC: The MCO will need to sign a standardized MOA, to be provided by the State, with each RPC for purposes of:

a. Service system planning.
b. Facilitating Medicaid linkages with social services and criminal and juvenile justice/courts and providers under contract with the county or State (initially NYC RPC only).
c. Coordinating provider and community training.
d. Coordinating support to primary care providers, ED, and local emergency management (fire, police) when BH emergent and urgent problems are encountered.
e. Data sharing: The MCO will share data directly with the RPC only with the coordination and approval of the State. Reports developed as part of the RPC process shall be approved by the State prior to public dissemination.