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

		transition age youth 21 and over may be determined eligible following completion of an eligibility screen.
7	How will rates reflect the costs for administering and managing BH HARP requirements?	HARP rates in NYC include 7.3% for administration and 1.5% for year 1 start-up costs. In NYC, this amounts to approximately $184.49 per member per month. This compares quite favorably to mainstream plans that only provide about $25 per member per month.
8	How will NYS modify provider expectations/requirements to align with plan expectations, e.g., integration of physical and behavioral health?	The integration of physical and behavioral health care is a key priority for New York State. NY is now developing an integrated license for providers and expects to issue these licenses throughout NYS in 2015. Over the next few years New York State (DOH, OMH and OASAS) will work with Plans to develop steps to achieve integration in primary care settings. The HARP will have an integrated premium and staffing requirements to reflect this priority. The RFQ also requires mainstream Plans to implement programs to manage complex and high-cost, co-occurring BH and medical conditions. Plans must also provide training for providers on integrated care. The RFQ has several integrated care requirements and specifically asks Plans to describe their experience with and/or planned approach to implementing BH-medical integration initiatives in section 4G.
9	Please clarify the definition of "health home care coordination" and the difference between the role of the health home role and the role of plan.	NYS continues to work with Plans and Health Homes to clarify the roles and responsibilities of Plans and Health Homes regarding care coordination. The general expectation is that Plans and Health Homes work as a team to improve the care that is delivered to Medicaid members: Health Homes provide care coordination services, including comprehensive care management and the development of person centered

		plans of care; health promotion, comprehensive transitional care; patient and family support; and referral and connection to community and social support services, including to non-Medicaid services. Plans use data to identify individuals in need of high touch care management; identify patients disconnected from care, notify Health Homes when members show up in ERs and inpatient settings; and, monitor Health Home performance under a uniform set of standards to be developed.
10	What role is the plan expected to play in creating provider capacity to deliver new 1915(i) services if there are gaps?	NYS has committed to the initial development of 1915(i) services. For the first two years of implementation, 1915(i) Home and Community Based Services will be paid on a non-risk basis by the Plans. Plans will act as an Administrative Services Organization (ASO) for NYS with regard to these services. NYS will identify and designate 1915(i) providers, provide a services manual, and establish initial 1915(i) payment rates. Plans will be able to recommend additional 1915(i) providers, subject to review by NYS. Plans will need to contract with a sufficient network of 1915(i) providers to meet the needs of their members.
11	Please clarify "In lieu" services (see page 14). Are these services different from 1915(i) services? What is the approval process?	Federal rules require that, with the exception of crisis services, the need for 1915(i) services must be identified in a person centered plan of care. Access to these services is also capped by hours and total dollars. Once a 1915(i) service is in an approved plan of care, the individual is entitled to receive that service. In contrast, unless they are prevented by contract, a Plan may provide cost-effective alternative services ("in-lieu of") that are in addition to those covered under the Medicaid State Plan. These "in-lieu of" services are alternative treatment services and programs.

		"In-lieu of" services could be identical to 1915(i) services for individuals in Mainstream Plans where 1915(i) services are not available. A HARP may also chose to use "in-lieu of" services to pay for additional 1915(i) services beyond those allowable under the per person hour or dollar cap established by NYS. Dollars for "in-lieu of" services will be paid by the Plans from their premium and are not separately reimbursed by NYS.
12	Can plans limit the number of health homes to which they relate?	Plans may limit the number of health homes they contract with. However, consumers must be given choice if possible and HARPs will need sufficient Health Home capacity for their members. Plans will not be able to compel their members already enrolled in Health Homes to move to a "preferred" Health Home with which the Plan would like to care manage its members.
13	What type of entity will provide the conflict free assessment?	Subject to CMS approval for members enrolled in a Health Home, the assessment will be completed by the Health Home with appropriate firewalls approved by CMS. Individuals who are not enrolled in a Health Home will have the assessment administered by the enrollment broker. NYS will be providing additional guidance on this subject.
14	In item 3.1.A (page 24), a footnote indicates that a Plan merger creating a new plan will not disqualify the new plan from offering behavioral health benefits. We understand this to mean that if the legacy plan meets the timeframe requirements the new plan is eligible, even if the plan resulting from the merger or acquisition has a new Medicaid number.	Yes this is correct.
15	3.1 Organizational Capacity: A. The Plan must be operating as a Medicaid	No. The Plan must have been operating as a Medicaid MCO in NYS as of 3/1/13 and on the startup date for this contract.

	MCO in NYS as of 3/1/13 and on the startup date. Can a Plan working with an experienced vendor, utilize the vendor's experience in Medicaid and/or as a Medicaid MCO to satisfy this requirement?	
16	Who does the assessments to determine HARP eligibility? Also what data was used to design the policy?	In general, HARP eligibility is based on a combination of behavioral health diagnosis and behavioral health service history (both Medicaid reimbursed and other). These are explained on pages 16-18 of the RFQ. Additionally, other individuals eligible for Medicaid managed care may enroll in the HARP if they have a behavioral health diagnosis and serious functional deficits as identified through the completion of a HARP eligibility screen. These may be people with a first episode psychosis; people leaving jail or prison; people discharged from a State psychiatric hospital, or people identified by the Local Governmental Unit (LGU)
17	§ Behavioral Health Transition Grants. Are you able to provide any additional information on the State's plans for allocating the $20 million in behavioral health transition grant funding (e.g., number of recipients, award amounts, funding by type of entity, selection criteria)?	New York is working on a plan for the distributing this money and will share details in the near future.
18	§ Home Visits. Can you please confirm that home visits for behavioral health clinic services will be covered under the community psychiatric support and treatment (CPST) 1915(i)-like service, addressing the current regulatory obstacles to coverage of home visits? How much funding do you anticipate being available to cover home visits?	1915(i) community psychiatric support and treatment (CPST) also includes treatment in the community as part of goal directed supports and solution-focused interventions intended to achieve identified goals or objectives as set forth in the individual's Treatment Plan. Pending CMS approval CPST services could be mobile but only for people who are determined 1915(i) eligible. There is no specific funding set-aside of funding for home visits.

19	§ *Crisis Services.* Could you please provide additional information on the options available to providers develop crisis/step-down beds and to convert existing residential beds into crisis beds? Plans report that providers are currently encountering regulatory obstacles as they attempt to do so. In addition, how much funding do you anticipate being available to cover crisis respite and intensive crisis support services through 1915(i)-like funding?	Some OMH licensed housing providers are requesting to convert some of their group home physical plant to crisis residences. The existing funding for the housing services would fund the same number of units in rental housing, freeing up the building. The providers will need a business plan to demonstrate that the crisis residence is sustainable from funding by health Plans. During the first two years, while the 1915(i) services are being billed FFS, we anticipate a limit of $5,000 per person in any 12 months unless the person changes plans. A Plan may provide more than $5,000 in crisis services, but they will have to pay for anything above $5,000 out of their capitation payments. After two, years, the exact amount of crisis services that will be built into the premium will be based on the 1915(i) billing history "trended" and annualized. It is unclear what regulatory barriers are being referred to, but both OMH and OASAS have the ability, under appropriate circumstances, to waive their regulations. The agencies will endeavor to work with the Plans to minimize regulatory obstacles to the implementation of the program.
20	Are 1915 Services excluded from the Mainstream Plans but included in the HARP?	1915(i) services are only available to individuals enrolled in the HARP and only if they are identified in their person centered plan of care. "In-lieu of" services could be identical to 1915(i) services for individuals in Mainstream Plans where 1915(i) services are not available. A HARP may also chose to use "in-lieu of" services to pay for additional 1915(i) services beyond those allowable under the per person hour or dollar cap established by NYS.
21	Members that go to Jail for extended periods 1+-6 Months, are they still enrolled in Managed Medicaid, BHO?	Managed care plans do not enroll incarcerated consumers. In cases where Medicaid knows of an individual's incarceration, the individuals are suspended from Medicaid and disenrolled from the managed care plan. Depending on the timing, individuals with short stays of incarceration (less than one month) may remain in a plan.

22	If Plan members are non-compliant with treatment and Health Home linkage, can they be restricted to fewer providers? To this end, is there a mechanism for disenrollment of members that are non-compliant?	HARP members who are not in a restricted recipient status may not be restricted to limited providers based on their refusal to comply with treatment or participate in a Health Home. Health Home enrollment is voluntary. At this point, Plans may not involuntarily disenroll members.
23	In the initial draft of the RFQ, I believe it stated that any "new" program to reduce costs would have to be approved by DOH prior to implementation, is that still the case? If so, this micro-management would hamper creative attempts to better manage this population.	NYS is balancing the need to safely transition the behavioral health system and service recipients into manage care with the need to transform the system to a more effective, community based and recovery oriented system. The RFQ establishes several transitional network requirements including the following: • Contracts for a minimum of 24 months with OMH or OASAS licensed or certified providers serving 5 or more members • Payment of FFS government rates to OMH or OASAS licensed or certified providers for ambulatory services for 24 months Plans and providers wishing to negotiate alternative payment methodologies for the first 24 months following implementation may do so pending State approval and subject to compliance with State and federal law. During the first two years of implementation, alternative payment arrangements must further the states' behavioral health transformation objective. Guidance from NYS will be issued at a later date.

24	As I contact MH residential providers regarding contracting with MCO's for commercial coverage for their residential programs two questions consistently arise. 1) Will SPOA play any role in placing Commercially insured members as the state does not fund their insurance? 2) Will OMH give guidance to these agencies that are reticent in contracting with the MCO's? If so when? Concern is that we are on a tight time frame 7/1/14 with offering this program, as per the Federal Government.	Rehabilitation supports in OMH community residences are not part of the capitation in year 1. OMH will be forming a work group to address the integration of residential supports in housing into managed care. OMH is currently reviewing the issue of access by commercially insured populations to OMH housing.
25	Is it possible to get the RFQ in Word Format?	NYS has released the RFQ in Word format on the DOH, OMH and OASAS websites.
26	If a health plan elects to qualify only as a mainstream MCO, will there be an opportunity at a later date to add a HARP program?	At this point, NYS is only qualifying HARPs through the current RFQ process. NYS may consider other qualifications in the future but no decision has been made at this time.
27	The definition of "delegated entity" (Section 2.0) limits the term to parent, subsidiary, affiliate and related organizations to which the plan will delegate certain responsibilities. Please confirm that the plan should limit its response to this subset of subcontractors with respect to questions in the RFQ that ask about delegated entities. Please confirm if the State wants this information provided for outside vendors that are not related to the Plan's parent company (third party vendors)? See sections 4.0, 4.0.B.3.d, 4.0.G.2.e, 4.0.J.4	The requests pertaining to delegated entities throughout section 4.0 refer to any entity to which the plan will delegate provision of administrative and/or management services through a partnership, subcontract or other agreement, including those that are named specifically in the delegated entity definition in section 2.0.

28	Regarding Section 3.2, many plans have parent companies with plans operating in other states. Many functions are provided centrally on a shared services model. Because of the level of integration of the enterprise, we believe that the experience of the enterprise in providing services in other states is relevant to the services contemplated in the RFQ. Examples of questions where we think this experience applies include, but are not limited to, 4.0.A. 4, 4.0.A.5, 4.0.E.8, 4.0.E.10 and 4.0.E.16. Please confirm that plans can reference experience of this nature in their responses.	With regard to RFQ questions concerning Plan experience, Plans may refer to experience within the parent company unless the RFQ specifically states that experience must have been in NYS. However, where appropriate, the response should tie this experience back to the RFQ and address how the experience will be applied in NYS, and how knowledge about NYS needs, geography and service availability will be provided to out-of-state staff.
29	If a plan can document a good faith effort, but is unable to agree to a contract with a provider, will these good faith efforts satisfy the requirement that plans contract with the specified type and required number of providers in Section 3.6?	NYS expects that Plans make every effort to comply with the contracting requirements in Section 3.6. NYS recognizes that there may be some circumstances or areas of the State where the requirements in Section 3.6 cannot be completely met. If a Plan cannot meet all Section 3.6 requirements, NYS will review the reasons why on a case by case basis and work with the Plans to ensure that the intent of these requirements is met as effectively as possible. In the first 2 years government rates will be used, so price will not be an issue.
30	Question 4.0.A.3 requests certain information regarding subcontractors that provide "administrative or management services required under the RFQ." Please confirm this request is limited to those subcontractors who will be engaged specifically for the services detailed in the RFQ. For example, a subcontractor providing peer review for behavioral health determinations would be included but an existing subcontractor providing 24-hour nurse-line would not be included.	A HARP is a new line of business with additional responsibilities. NYS (DOH, OMH and OASAS) desire the opportunity to review the experience and performance of all entities (including subcontractors) supported with Medicaid funds.

31	Questions 4.0A.4 and 4.0.A.5 ask the plan to identify years, customers and other information relating to its management of behavioral health, please confirm that the plan should include information on contracts in which it was required to manage behavioral health for its members but the plan subcontracted that function. We understand that the response should indicate that the behavioral health function was subcontracted in those situations.	If the management of BH for other contracts was subcontracted, the respondent should reflect this in its response. For any questions that pertain to a function that will be delegated, the response may and should reflect the experience or capability of the organization to which that function will be delegated. On any item where "the responder" includes a delegated entity, clearly identify the role of the Plan as distinct from the role of any delegate(s) and the name of the delegate(s) within the response.
32	Regarding the state's vision in Section 1.5.A.iv that would have health plans responsible for managing admissions and discharges from State hospitals, will the state be providing a transition plan that includes a timeline or proposed timeline for the shifting of admissions and discharge management to the plans?	NYS OMH psychiatric centers admit about 6,000 persons per year. A substantial minority are adults enrolled in Medicaid Managed Care. Most are transfers from Art 28 hospitals. Most are transferred long after the patient has had 30 psychiatric inpatient days. Most of these patients could be discharged from OMH with comprehensive "wrap around" housing, treatment and rehab services. OMH's objective is to outline how the Plans can and will reduce referrals. This objective is imbedded in the revised psychiatric inpatient Stop-Loss proposal currently being discussed with Plans. It is the expectation, that with more accountable ambulatory networks, higher quality care management, and improved discharge planning from inpatient settings, there will be fewer people referred to State psychiatric hospitals. NYS is also exploring other mechanisms to incentivize Plans to reduce the lengths of stay of their members who are admitted to OMH inpatient facilities.

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

36	Regarding training requirements in Section 4.0.E, relating to provider training, is there an expectation that plans work jointly to provide universal training?	Whenever possible, training and education for providers should be provided in coordination with the Regional Planning Consortiums (RPCs). In NYC, this function will likely be managed by the NYC Department of Health and Mental Hygiene. RPCs will be created in a number of regions of the State to guide behavioral health policy in that region, problem solve regional service delivery challenges, and recommend provider training topics.
37	Regarding the experience requested in Section 4.0.E, question 8, is the State looking for specific experience in a specific contract with NYS, or can we pull relevant experience from another state served by one of our affiliate plans?	With regard to RFQ questions concerning Plan experience, Plans may refer to experience within other states unless the RFQ specifically states that experience must have been in NYS. For this question, the experience may be in other states. However, the question also asks Plans to relate this experience to your plan for BH in NYS.
38	Regarding Section 4.0.G, question 11, are plans expected to contract and coordinate with all AOT service providers similar to other provider types?	Assisted Outpatient Treatment (AOT) is court-ordered participation in outpatient services for certain people with serious mental illness who, in view of their treatment history and present circumstances, are unlikely to survive safely in the community without supervision. An AOT treatment plan may involve a variety of different services delivered by different providers. These providers may or may not be under a Plan contract. However, Plans must reimburse for these court-ordered services as per the terms of the model contract, provided that such ordered services are within the Plan's benefit package and Medicaid reimbursable. Additionally, plans are responsible for ensuring that the AOT plan of care is being met; that AOT reporting requirements are being met; and that people with an AOT court order are assigned to the proper level of care management.
39	Regarding Section 4.0.G, question 11, how will the Plan know that a member has received an AOT?	AOT plans are managed the Director of Community Services in each county. As required in Section 3.3Q, Plans will need to have liaison staff to work with a number of member serving systems including counties. Plans will be provisioned with information on who has an active AOT

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

43	Regarding all questions in section E,F,G,H, and I: Would responders be allowed to exceed the page limit for specific questions if the total number of pages submitted for that section meets the section's total page limit?	No. Unless attachments are specifically allowed in the RFQ or newly allowed in another FAQ answer.
44	If a member is receiving peer services in an OASAS clinic setting, does that preclude him or her from receiving peer services elsewhere? For example, there is a recovery peer in the OASAS clinic, but could there also be a peer who functions as a community health worker?	1915(i) Peer services are separate and distinct from other treatment services that may include a peer component.
45	In discussions with some behavioral health providers, they have interpreted certain sections of the RFQ to mean that HIV SNPs could only manage the HARP benefit for people enrolled in the HIV SNP (not HIV negative populations). Is this the case -- that there will be "HIV SNP" HARPs? Or will an HIV SNP that achieves HARP designation be able to enroll HIV negative populations in its HARP?	At this time, an HIV/SNP approved to be a HARP would only be a HARP for its HIV members. NYS is considering options for non-HIV positive populations enrolled in an HIV/SNP.
46	Regarding the NYS Request for Qualification Package (RFQ) to a become Health and Recovery Plans (HARP). Section L – Financial Management, Items 4b – 4d request that MCO applicants provide financial projections. Is there a specific template that should be completed? Alternatively, are there any specific guidelines to be considered regarding how the financial statements are organized?	NYS has developed a template. It will be made available on the OMH, OASAS, and DOH websites and will be distributed shortly.

47	Regarding question 4.0.A.13, please confirm that this question is requesting information only about sanctions and other types of non-compliance notices that involve financial penalties. Audit findings, notices of non-compliance and similar written notices without financial penalties are standard elements of servicing government programs. If these non-financial items are required to be included in the response, would DOH, OMH and OASAS consider extending the page limit to ensure respondents can provide all of requested information?	You should list out as succinctly as possible, but with clarity, all the instances of notification of non-compliance listed in the question. You should then make the required listing of financial sanctions. Since this is not a question regarding a proposed means to qualify, or a specific qualifications, if you have to run over one page to detail all of your instances of non-compliance, that will be permissible.
48	Will Health Home service plans be subject to approval by HARP MCOs? (Section 1.8/1.9)	Yes
49	Will all HARP members be offered the opportunity to enroll in a state-designated Health Home? (Section 1.8/1.9)	Yes
50	Will HARP plans be authorized to provide Health Home services? (Section 1.8/1.9)	No. However, the state is looking to allow Plans to develop an interim care management approach for HARP members until all HARP members are enrolled in Health Homes.
51	With HARP initiation on January 1, 2015 in NYC, what will the timeframe be for members currently unassigned to be enrolled in a Health Home? (Section 1.8/1.9)	NYS is working to enroll as many NYC HARP eligible members as possible prior to January 1. The expectation is that Plans will work to enroll members in Health Homes as rapidly as possible.
52	How will 1915(i) services be priced? (Section 1.11)	NYS will establish prices for 1915(i) services for the first two years and guidance will be issued.
53	What will the process be for authorizing providers to offer 1915(i) services? Will this require licensure or certification? (Section	NYS will designate 1915(i) providers and licensure is not required.

	1.9/3.6)	
54	What will the appeals process be for determinations regarding a HARP member's eligibility for 1915(i) like services and the approved scope/number of such services? (Section 1.8)	An appeal process for 1915(i) eligibility determination and 1915(i) service determinations will be implemented within the MCO's existing appeal process including a right to a fair hearing. The timeframes for an appeal will be consistent with the standard Medicaid contract.
55	What are the timeframes for 1915(i) service development? Is there a certain percentage of development funds that are required to flow to providers? (Section 1.10)	The plan for funding 1915(i) services will be shared as part of an overall guidance document being developed. HARPS will need to have an adequate network of 1915(i) services prior to beginning operations.
56	For plans that contract with a BHO, will all expenses for such a service be included as medical loss or will a portion be considered administration? (Section 3.16)	The allowance in the calculation of the MLR and "risk corridor" for administration and "start up costs" includes the administrative expenditures of the HARP and the administrative costs of the BHO.
57	How will Health Home expenses be treated relative to medical loss allocation? (Section 3.16)	Health Home expenses are counted as medical loss for the purposes of arriving at a medical loss ratio. As HARPs commence, both State payments to the HARPs that are passed-through to Health Homes for care management and the State approved amount of the Health Home payment which is retained by the Plans (not to exceed 3.0%) are excluded from the calculations surrounding the MLR and "risk corridor".
58	What are the plans for a stakeholder advisory committee to offer input into the transition of behavioral care into managed care? (Section 3.12)	The MRT BH workgroup will continue to provide input on BH managed care implementation. Additionally, Regional Planning Consortiums will be created. These will provide an opportunity for stakeholder input.
59	Is there a process for plans to seek approval for "in lieu of" services? (Section 1.10)	No specific process is necessary. Plans may provide "in-lieu" of services unless such services are prohibited by the federal government or by their contract with the State.
60	How will plan utilization management criteria be made transparent to members? (Section 3.9)	Plans are required to describe their process for achieving this objective in their RFQ submission.
61	Will limits on opioid treatment services be allowed? (Section 1.10)	Opioid treatment should be managed based on medical necessity criteria with no mandatory limits applied. Long term opioid agonist and partial agonist treatment are evidence-based treatments for the management of

		opioid dependence.
62	What steps will NYS take to review and revise program regulations to insure consistency with managed care and encourage integrated services? (Section 1.10/3.5/3.6)	NYS will be creating a regulatory reform workgroup. Currently, NYS expects to begin this work in the fall of 2014.
63	Is it anticipated that some HARP eligible members will move out of HARP plans in the future and, if so, what will be the process and criteria for such a determination? (Section 1.8/1.9)	HARP members are free to change Plans according to the current managed care rules. At this time there is no mechanism for involuntary disenrollment of HARP members.
64	How will the reinvestment of any behavioral savings be managed and made transparent to the public? (Section 3.16)	Behavioral Health Savings are the recoupments from the HARPs and mainstream MCOs of any under expenditure of the minimum Medical Loss Ratio established in the State-Plan contracts. The under expenditures, if any, will not be determined until sometime after the close of each program year (which will be SFY) after review of each plan's submitted annual financial report. The State will publish the "savings" (and "losses") for each plan in each rate region as soon as they are known. The exact process for "reinvestment" will be developed in the first year of implementation and will include input from stakeholders.
65	Will members of HARP plans have access to the same medical and specialty networks as members of other service lines in the MCO? (Section 3.5)	Since HARPs are a line of business within existing Plans, NYS expects that HARP members have the same access to medical and specialty care as members in the mainstream Plan.
66	Will Medicaid FFS rates be applied to all outpatient services, not just clinic services? (Section 1.11)	Medicaid FFS rates will be applied to all OMH licensed and OASAS certified providers for 24 months from BH managed care implementation.
67	If a significant portion of a Plan's eligible membership decline enrollment in a HARP, will there be an actuarially sound capitation rate adjustment that will reflect the higher acuity rate of non-enrolled, but otherwise high-need/high-cost Plan members?	The resources included in the calculation of the HARP premium for all HARP eligibles will be restored to the mainstream MCOs when the number of HARP enrollees is determined. The restoration will be effective January 2015 in NYC, and July 2015 in the Rest of State.

68	Please define what the State means by a "conflict-free functional assessment from an appropriately qualified individual." What does the State deem "conflict-free" and what are the appropriate qualifications for this individual?	The HARP design utilizes Health Home Care Coordinators to complete the functional assessment by using CMS appropriate firewalls that address the conflict free standard (e.g., offering choice of providers, etc.). All Health Home Care Coordinators who conduct the functional assessment will need to receive training on the tool.
69	Is the HARP eligibility screen a State developed tool? Please define and provide additional information.	NYS is in the process of developing the HARP eligibility screen. More information will be provided at a later date.
70	Please provide additional information on the State's expectation of the interRAI "derived" tool.	The State will utilize a modified version of the Community Mental Health suite of the interRAI to meet CMS requirements, which requires that a comprehensive functional assessment be completed to develop a plan of care that includes 1915(i) services. A shorter HARP and 1915(i) eligibility and assessment tool will be utilized as well.
71	1.9 i Please specify timeframe health Plan must notify members of their HARP eligibility.	The Plan does not notify members of HARP eligibility. That will be the role of DOH and the enrollment broker. A mainstream Plan may, however, refer a member for a HARP-eligibility assessment.
72	Please expand on definition of medically necessary services.	New York law defines "medically necessary medical, dental, and remedial care, services, and supplies" in the Medicaid program as those "necessary to prevent, diagnose, correct, or cure conditions in the person that cause acute suffering, endanger life, result in illness or infirmity, interfere with such person's capacity for normal activity, or threaten some significant handicap and which are furnished an eligible person in accordance with state law" (N.Y. Soc. Serv. Law, § 365-a). The following supplemental language is taken from the RFQ: Medical Necessity Criteria (MNC) are used by Plans to determine appropriateness of new and ongoing services. NYS supports a person-centered approach to care in which each Enrollee's needs, preferences, and strengths are considered in the development of a service plan. Plan care managers should view each authorization for a specific level of care within

		the larger context of the Enrollee's needs to support sustained recovery from a serious mental illness or substance use disorder. When an Enrollee no longer meets MNC for a specific service, the Plan should work with providers to ensure that an appropriate new level of care is identified, necessary referrals are made, and the Enrollee successfully transitions without disruption in care. Plans also should have processes for ongoing monitoring an Enrollee's need for new care management services, including defined triggers for referrals to Health Homes and HARP services.
73	Can the State disclose whether there will be a separate rate cell for new cohorts carved in?	This is not known at this time.
74	Can the State expand on definition of Care coordination?	The definitions of Care Management and Care Coordination are included in the Health Home State Plan Amendment (SPA) approved by CMS. The definition can be clarified and guidance may be provided but each must comport to the definition contained in the Health Home SPA.
75	Can there be a payment incentive worked into the rate for care management?	New York State is exploring options for the structure and reimbursement for care management in cases where a Health Home is not involved.
76	Will the State please provide the suggested UM criteria to be utilized for forensic behavioral health services?	Plans must reimburse for court-ordered services as per the terms of the model contract, provided that such ordered services are within the Plan's benefit package and Medicaid reimbursable.
77	Regarding Opioid Treatment Programs- Will the State consider accounting for quality differences in programs?	Yes, OTP programs are considered essential providers to protect access to care in the transition. Managed care companies will be able to influence quality differences through referrals, utilization and review and performance management.
78	Will the State consider setting a certain percentage (e.g., 75%) to allow for selection of 'best' practices?	Assuming that this is related to #100, during the transition period, 100% of OTP providers in a region will need to be empanelled to ensure access to services and continuity of care. OASAS will work with providers and plan as we move forward to allow for a transition to a more limited network based on quality and value.
79	3.6 h i. How does cognitive and behavioral status or ability impact the consent of a HARP enrollee	The member signature must be secured to the Health Home Patient Information Sharing Consent Form (DOH 5055) by a Designated Health

	to elect a Health Home?	Home in order for Medicaid members to authorize full access to their personal health information for the purpose of the Health Home providing care management. By signing a Patient Consent Form, the Health Home member will be able to receive the full benefit of Health Home services. While the member may be able to work with a care manager without signing a consent, the care manager will not be able to help the member get other services unless the consent form is signed.
80	How is the State defining inclusion?	Inclusion refers to "community inclusion". Community inclusion is the full participation by an individual living with mental illness and/or substance use disorders in living arrangements, activities, organizations and groups of his/her choosing in the community.
81	3.10 Can the State explain what is the interRAI platform?	The interRAI is a functional assessment tool that includes several suites designed for specific populations. The Department of Health has included several of these suites in its Uniform Assessment System (UAS). HARPS will utilize the Community Mental Health Assessment suite.
82	3.10 c v Can the State clarify whether this pertains to an EMR or are HIPAA compliant emails, faxes and FTPS acceptable? Can Plans share access to systems with providers?	This clause applies to any exchange of protected health information (PHI) between a Plan and any entity it subcontracts with to support management of behavioral health benefits. All procedures for sharing PHI must meet applicable state and federal regulations.
83	Can the State identify the RPCs?	The RPCs are in the process of development. More information will be released as it becomes available.
84	3.16. b Can the State please provide definition of behavioral health categories (MEDSIII style definition)?	This information is forthcoming and will be distributed prior to implementation.
85	3.17 a When does the State anticipate releasing the quality measures for the mainstream and HARP products?	The State anticipates releasing quality measures for Year 1 in Fall 2014.

86	3.17 bii What other components aside from QARR measures will be incorporated into the quality incentive program? How will statistical significance be calculated?	For HARPs, the existing mainstream plan QI methodology will be used with the initial addition of compliance with reporting requirements and other administrative measures. Additional behavioral health measures will be included as they are incorporated into QARR. Statistical significance will be calculated in the same fashion as it is currently calculated for mainstream plans.
87	3.17 biv Will the quality incentive components be shared with the Plans in advance of reporting at least in the startup years?	Yes
88	I. Quality Management Can the State provide examples of other stakeholders that may need to be included in the development and ongoing work of the quality management system?	Examples of other stakeholders are peer specialists, subcontracted Plans, RPCs and other member serving agencies.
89	How does the State envision relationships between the Plan and with Mobile Crisis Teams and 911/fire rescue in local communities?	NYC DOH Mental Health funds mobile crisis teams. The State will be working with New York City to develop guidance on NYC mobile crisis teams and Managed Care.
90	How did the State arrive at the 90% MLR? This population will require significant care management; and the program will require a level of oversight more consistent with FIDA and other special populations which requires significant clinical oversight and non care coordination staffing resources. As such AER will be higher than 6%.	This is based on historical reported data. The MLR in mainstream Plans averages 90% and the MLR in HIV SNPs averages 94%.
91	What SNF units are being developed or are currently available by region to meet the unique needs of members with behavioral	Currently no skilled nursing facilities (SNF) are being developed specifically for individuals with behavioral health (BH) needs. The Federal Preadmission Screening and Resident Review (PASRR) process

	health issues?	prohibits individuals with acute BH from being admitted to a SNF. All SNF are required to provide non-acute BH treatment to individuals requiring such care.
92	Performance Improvement Plan Updates Can the State please describe "Performance Improvement Plan Updates" that the Plan will be required to make on a quarterly or more frequent basis? Will Plan's participating in both the Mainstream and HARP products be required to submit separate reports?	This refers to progress reports on the action plans that are currently required when a Plan's performance is poor on select quality measures. Mainstream and HARP products will be required to submit separate reports.
93	When does the State anticipate the first QARR reporting year to be for the Mainstream MCO? For HARP?	The mainstream MCOs will continue to report QARR data on schedule. As is done now, new QARR measures will be available publicly only in aggregate the first year they are reported. For HARPs, Year 1 QARR data will be reported to NYS DOH, though plan to plan comparisons will not start until Year 2.
94	Will a work group be established to develop the performance measures that will be included?	A work group with representatives from state agencies has been working on developing performance measures; other stakeholders may be included in the future.
95	Will the State make its registries and various pertinent databases available to Plans to research history, DOS, data, etc.?	NYS will supply "recent" Medicaid (and MMC) service history for HARP members.
96	In order to complete contracting requirements it is essential for Plans to have the fee-for-service codes and current Medicaid rates for all benefits listed in this RFQ (please reference Table 1. Benefits in Mainstream MCOs for all Medicaid Populations 21 and over and Table 2. HCBS Services for Adults Meeting Targeting and Functional Needs.) When do you	NYS anticipates sharing this information before August 2014

	anticipate being able to share this information with Plans?	
97	Can NYS provide a comprehensive list of all licensed providers including essential providers?	A list of these providers have already been distributed to Plans.
98	In question B.6 of the RFQ, Plans are required to complete a functional staffing chart. Should the chart be completed based on current staffing or proposed staffing post implementation?	Plans should complete the chart and include both existing and planned staff that will be on board prior to implementation. Plans need to identify which staff are existing and which staff are planned. During the readiness review, NYS will check to ensure that Plan staff have been hired and are properly trained.
99	Given the volume (approximately 600 pages) of the sample report requirements in Section 4.0 of the RFQ, question J.1c (referencing Attachment A, B, E) will NYS allow Plans to provide these sample reports only in the electronic submission and not include them in the hardcopy response?	The sample reports requested in Section 4.0 question J.1.c may be submitted only electronically. The RFQ response must clearly indicate that the Plan has submitted them electronically. The RFQ response must identify the specific file names and contents and how the report addresses question J.1.c.
100	If a member refuses to enroll in a Health Home but qualifies for Health Home services and the Plan provides those Health Home services, will the Plan receive the Health Home payment?	NYS and the Plan Associations are discussing payment for HH services for HARP members. More information will be released at a later date.
101	Our organization has determined that we will need to subcontract with a BHO organization, however, BHO will not be fully contracted by RFQ submission due date. Please detail how we should structure our response to the RFQ. For Example: Prior to contracting we will not have access to the all specific details on BHO organization by the due date. We respectively request guidance and direction as part of the May 2nd meeting on this overarching issue.	For the RFQ application submission, please respond based on the Plan's current experience and organizational capacity. Describe any areas or gaps that exist that require subcontracting with a BHO. The Plan should provide a proposal for how they will address these gaps by August 1, 2014. If this is the case, a follow up submission will be required showing how the BHO will be integrated into Plan operations to meet the requirements of the HARP by August 1, 2014, prior to NYS readiness reviews.
102	Regarding BHO vendors, is the State providing any type of automatic-qualification for those	No automatic qualifications are being made.

	vendors who were involved / participated in the BHO-1 demonstration project?	
103	Can the State provide additional guidance on the classification and qualification of Mental Health Detox vs. Medical Detox?	Medical Detox is the use of medications and social interventions to provide safe withdrawal from alcohol and other substances. There is no mental health detox.
104	RFQ states "Plans shall submit electronically to the Health Commerce System (HCS) an updated provider network report on a quarterly basis….The report submission must comply with the Managed Care Provider Network Data Dictionary". When will the Data Dictionary be updated to reflect the new provider types and specialty codes for HARP?	The Data Dictionary will be updated as necessary in time for HARP implementation.
105	Will member incentives be used and will there be any DOH funding for studies/ PIP's?	Member incentives are allowed within the limitations of the current Mainstream Managed Care Contract. No additional funding is provided for studies/PIPs.
106	Has any reporting from the State showing which agencies/providers are servicing more than five of our current members been made available to date and if not, when can we anticipate the release of this data?	Yes, a list of NYC metropolitan providers serving more than 5 members will be provided by July 2014.
107	RFQ states that in network development we must consider anticipated enrollment in Mainstream Plans and HARPs, and enrollment from other Plans; Will these projections be provided to Plans?	Plans will receive the complete roster of persons eligible to enroll in HARPs already in their Mainstream Plans some time before the HARPs commence operation in NYC and ROS. NYS has no way of anticipating the Plan elections of HARP eligible individuals in Mainstream Plans that do not develop HARPs.
108	RFQ states: Special procedures for HCBS provider credentialing will be developed by the State in consultation with the Plans to ensure credentialing consistent with the approved HCBS provider qualifications. The Plans	Plans may not credential any potential 1915(i) providers without NYS approval. NYS will be identifying potential 1915(i) providers over the summer. More information will be provided as it becomes available.

	credentialing committee shall adhere to these procedures. As we have already begun contracting with these providers, this information is critical. Is there a date when the credentialing guidelines will be made available?	
109	Given the already significant reduction in institutional care, what effect does the state anticipate on different geographic areas regarding membership as NYS continues to reduce state hospital beds?	The census decline in OMH facilities outlined during the RCE regional meetings is now projected to be much slower than originally represented. Much of the census decline among adults will be individuals enrolled in Medicare who will for the foreseeable future be ineligible to enroll in Medicaid Managed Care/HARPs. The projected Statewide increase in Medicaid Managed Care enrollments by adults linked to OMH's projected census decline will be only a few hundred each year.
110	NYC document states plans must be operational as of 3/13 to submit application. What will the rule be for plans that had a change in ownership but are continuously operating (this will impact us as TONY d/b/a Total Care – but TONY license is as of 12/1/13	A Plan merger creating a new Plan will not disqualify that new Plan from managing the behavioral health benefits.
111	Longer term expectation that plans are financially responsible for IP – can they estimate a calendar? And what tracking/quality metrics in place for pre financial risk	NYS and the Plan associations are discussing the time table for stop-loss transition. Once this information is finalized it will be shared with Plans.
112	It appears that criteria for HARP are primarily poor utilization rather than differential diagnoses. How does the state plan to address who members would be; when they "graduate"; and how to identify those most at need once the programs are running and care is better coordinated via plan services? That is, the risk factors may change quickly depending on interventions and the population may churn more than expected, creating challenges to	Designation for HARP enrollment is primarily based on diagnosis and BH service utilization. To the extent that BH diagnosed individuals are not engaged in care, they are also candidates for a HARP but would require a separate eligibility assessment. HARP members are free to change Plans according to the current managed care rules. At this point, Plans may not involuntarily disenroll members as their needs change. Mental illness and substance abuse are often chronic illnesses.

	continuity of service for members.	Once HARPs are operational, NYS will examine the clinical circumstances under which it would be appropriate for a HARP enrollee to move back into a mainstream Plan.
113	Is the HARP responsible to conduct the assessment using the InterRAI Assessment Suite?	Health Home care managers and/or enrollment brokers will be conducting the HARP/HCBS eligibility assessments.
114	Will mainstream MCOs provide HARP services for HARP-eligible members in the event there is no HARP in the MCOs region?	NYS expects to have HARP coverage throughout NYS. At this point there is no plan to have mainstream Plans provide HARP services.
115	The alternative says new staff can meet the experience requirements – does that mean together or individual resumes?	Managed Care Plans must describe how their existing and or new staff meet the requirements of the RFQ.
116	Does the HARP RFQ response have to include named individuals for key staff requirements at time of submission?	No, however, NYS maintains the right to review and approve individuals filling these positions (Section 3.3.M of RFQ). A Plan that does not have key personnel identified at submission must notify NYS upon hire of such individual(s). In addition, Plans must notify NYS of names and qualifications of individuals filling the key staff responsibilities (even if interim) no later than 120 days prior to planned implementation.
117	Integrated PH/BH – does this reference mean colocation in the same office or integrated via process.	Depending on conditions, circumstances, and roles, integrated PH/BH initiatives will include combinations of revised processes as well as co-location of staff. NYS looks to Plans to describe their approaches to achieving the level of integration described in the NYS vision statement and throughout the RFQ.
118	For Table 3 cells that say "All" – is NYS requiring providers such as State Operate Outpatient Programs to contract with all MCOs/HARPS who invite them to enroll in the network?	All Plans must contract with ALL State operated outpatient programs in the counties where the Plans operate.
119	When will VNSNY CHOICE SelectHealth receive a list of its HARP-eligible members?	This information was sent to all Plans including the SNPs in May 2014.
120	Is there a rate sheet available for the Behavioral Health carve-in? If not, when is it expected to be available?	HARP rates can be found on slides 9 and 10 of the Applicants Conference PowerPoint presentation. The link to this presentation is below, Rates presented must still be approved by the New York State Division of the

		Budget and the Federal Centers for Medicare and Medicaid Services http://www.omh.ny.gov/omhweb/bho/applicants-conference.pdf
121	Is there a recommended format or template for the response to the RFQ?	No, there is no specific template for the RFQ. However, Plans must stay within the page limits provided in the RFQ unless there is an exception allowed in an answer to a question in these FAQs.
122	Risk Mitigation 1915(i) services will be paid by pass-through for the first two years. Please confirm that these services are not included in the calculation for the proposed risk corridor (as described in the DOH presentation (Behavioral Health HARP Risk Corridor Proposal dated April 4, 2014) 3,16	They will not be included in the risk corridor calculation.
123	Risk Mitigation / Corridor In the proposed risk corridor, there's an allowance of 8.5% for administration and start-up costs. In the rate, the administration load is 6.9%. Will the rate get updated to reflect the 8.5% administration and start-up costs in the risk corridor	No, the rate sheet now says 7.3% for administration. We will add the start-up allowance to that and disallow any administration above that amount when we do the risk corridor calculation.
124	The state indicates that a BHP has to be a person with an unrestricted license to practice independently. The state also requires plans to hire CASACs. Is the state's expectation that the CASACs also have a license to practice independently?	In the RFQ where a Behavioral health practitioner is needed for the purpose of Utilization Review or other Managed Care functions– a CASAC alone would not qualify. All practitioners in an OASAS certified clinic will be reimbursable by the Plan.
125	Will the state consider allowing additional or specialized case management support to be provided from locations outside of the state of New York? Is the state requiring CMs to be on site without any possibility of hiring remote	Health Home care management will need to be provided where the person resides. Health Home care management cannot be provided remotely.

	CMs linked to the NY office?	
126	For services / populations being covered year 2 – is there an expectation that plans contract for these services prior to going live?	Plans are not required to contract for year two services such as residential supports prior to the go live date.
127	LOCADTR – Are plans required to base our criteria on LOCATDR or are we required to use LOCADTR as written and posted on the OASAS website.	OASAS is revising the current LOCADTR tool. It will be a web-based tool with logic based on the individual risks and resources of the individual client. The tool will yield a level of care recommendation.
128	Can the State further clarify attachment C – some of the benefits overlap and some services may be provided in OP clinics as part of treatment. For example – Habilitation and Rehabilitation cover similar services; rehab counseling could be part of a member's OP clinic treatment. Can the State break out where these services are provided (setting), who can provide each service (provider type) and provider qualifications?	A 1915(i) provider manual is currently being finalized that will provide specifications on the service components of the 1915(i) services, the setting of the service, and provider qualifications. The provider requirements will then be utilized to designate providers that can deliver the 1915(i) services.
129	Please provide an update to the MEDS directory to include the enhanced benefits for encounter reporting?	This is forthcoming and will be available prior to implementation.
130	**Section 3.9.A** Is the state considering an approved, standardized, state Medical Necessity Criteria (MNC) for all plans to follow? Standardization of MNC will not only help patients and providers during this transition, but it will also decrease the administrative burden and costs to the entire health care system.	NYS requires that the LOCADTR tool be used for making prior authorization and continuing care decisions for all SUD services. NYS is not requiring Plans to use a specific MNC guideline for mental health services. Plans must submit the MNC level of care guidelines they propose to use for mental health services to NYS for review and approval.
131	When a change in level of care is indicated,	Plans must demonstrate to NYS that they have the expertise to manage the

	how will Plans work with providers to ensure necessary referrals are made and the enrollee successfully transitions without disruption of care?	care of individuals with Behavioral Health needs. The Plan's RFQ response to various RFQ questions should demonstrate to the State how the Plans will to use their expertise (with our without a BHO), and Health Home staff to achieve this objective.
132	**Section 3.9.E.iv.c** Will plans be required to have clear definitions of their responsibilities regarding relapse/crisis prevention planning?	Plans should have a clear process articulated for ensuring access to crisis services. Plans should be able to manage high needs behavioral health patients.
133	**Section 3.9.F** The RFQ states that MCOs shall require all BH admission and continued stay authorization decisions be made by a U.S. BH provider (BHP) with a minimum of three years of clinical experience in a BH setting. However, **Section 3.9.P** requires that a physician board certified in general psychiatry must review all inpatient level of care denials for psychiatric treatment and a physician certified in addiction treatment must review all inpatient level of care denials for substance use disorder (SUD) treatment. HANYS and its members feel that Section 3.9.F should be tailored to match the requirement of 3.9.P and state that the BH admission and continued stay authorizations must be made by a U.S. BHP with a minimum of three years of clinical experience in a ***relevant*** BH setting.	The suggestion that experience should be in a relevant BH setting, is appreciated. NYS will consider this when reviewing RFQ submissions.

134	**Section 3.10.C.iv.d** What types of corrective action protocols are Plans allowed to have for providers who do not perform to the standards in this section?	NYS will use the current DOH process including corrective action plans. Providers who do not meet certain performance standards will not have access to performance incentive payments.
135	**Section 3.16.B.i and 3.16.G.i** For Plans that fail to perform up to the requirements in the RFQ, how will statements of deficiency and/or funding take-backs be interpreted by the state in relationship to future funding?	NYS will use the current DOH process including corrective action plans. Providers who do not meet certain performance standards will not have access to performance incentive payments.
136	Will Plans be required to track expenditures for BH from year-to-year and report this to the public?	NYS will track BH expenditures and report these publically.
137	**Section 3.16.F.ii** When will the state determine whether or not it is going to go with a total individual stop-loss?	At this point NYS is unlikely to use a total individual stop loss that includes inpatient MH.
138	Can the RFQ be hand-delivered to the State?	Yes, RFQ responses can be hand delivered. Proposals to serve the New York City region must be submitted in a sealed package and received before 5:00 PM, EST, on June 6, 2014 to the address below: Susan Penn, Contract Manager Attn: MCO and HARP RFQ Office of Mental Health, 7th floor 44 Holland Avenue Albany, NY 12229

139	Government Community Liaison - what is the definition of this role?	The Governmental/community liaison works on behavioral health issues with New York State, county behavioral health leadership, and RPCs within its service area. Plan liaisons attend relevant stakeholder, planning, and advocacy meetings and communicate/coordinate with other staff in the Plan as necessary to ensure that the Plan is aligned with NYS and local BH initiatives.
140	How will the state communicate voluntary enrollments to the plan either through the 834 file or the Roster?	At the present time, for WMS domain consumers, the State will pass enrollee information through Roster/Reporting files, available on the Health Commerce System. For consumers who enroll through the New York State of Health (NYSoH) marketplace, enrollment information is passed through an 834 format. SDOH has plans to convert from Roster reporting to 834 transactions, but an implementation date is not available at this time.
141	IF the state will communicate passive and voluntary enrollments to the plan via an 834 file when will the plan receive the 834 companion guide?	Upon program inception, all State created Electronic Data Interchange (EDI) documentation would be made available to the HARP plans for programming.
142	If the state will communicate the passive and voluntary enrollments to the plan via the roster when will the state provide more information on how these members will be identified on the roster?	Demographic and coverage information will appear on the roster or 834. If the enrollment broker is used, supplemental reports will be available. Clinical information will not be available through this avenue.
143	How will the state communicate disenrollments to the plan? Will the state identify these members by using an exception code, if yes what is the code? Will these members be assigned a different rate code and if so what will this code be?	Plans receive a monthly Provider Disenrollment Report, for WMS domain enrollees. However Plans should cover only those who appear on their rosters, with few exceptions. For consumers in the SoH, 834 files will pass an effective date of enrollment. The plan is to cover this consumer until a subsequent 834 comes with a termination date.
144	Does the State intend to provide metrics for	Yes

	plans to use in assessing HH experience and competencies to work with this population?	
145	State requires dedicated 800# for HH contact for coordination with plan. Will alternative strategies be entertained? (E.g: a designated point of contact for HH CM)	No
146	Where crisis intervention services are utilized for HARP members prior to completion of InterRai and establishment of need based care plan can continuation of 1915(i) services be approved by plan pending InterRai assessment without risk of payment denial?	Plans can always pay for services on an "in lieu" of basis. With the exception of crisis services, 1915(i) services must be in an approved plan of care before they can be reimbursed as 1915(i) services.
147	Will state identify plan members who have been receiving crisis services in 2013 prior to enrollment?	The Plans will receive the Medicaid and Medicaid Managed Care reimbursed behavioral health service history of their members sometime after final designation. The history will identify Comprehensive Psychiatric Emergency Program (CPEP), clinic crisis and ER visits with a behavioral health primary diagnosis. The State has no patient-specific information for non-Medicaid reimbursed crisis services.
148	State provides definitions of case management, care management and care coordination. Are their minimal requirements, standards set by the state for who is "appropriately qualified" to fulfill these functions?	Plan staff carrying out care management and care coordination should have the qualifications as stipulated in the RFQ: All utilization/care management staff must be U.S. licensed BHPs. Some of these staff should include individuals who are Certified Alcohol and Substance Abuse Counselors for concurrent review of SUD services.
149	Regulations limit /restrict info sharing related to SUDS, (HIPPA and State law 42 CFR part 2). RFQ requires protocols to support integrated care management and data sharing in compliance with privacy laws. Are there plans to address regulatory barriers to info sharing which is used for integrated care.	OASAS will develop 42 CFR Part 2 compliant consent forms which will allow integrated care management to occur. OASAS worked with DOH to develop a 42 CFR Part 2 compliant consent form which allows for the sharing of information between Health Home providers.

150	Are there recommended approaches for measuring improved individual health and BH life outcomes?	For HARPs, the state plans to measure BH life outcomes with consumer surveys and data from HCBS eligibility assessments. Individual health outcomes can be measured with the above, with the addition of administrative data. Plans are also encouraged to describe their approaches and measures for addressing specific health and BH life outcomes consistent with the NYS vision and clinical management requirements specified in the RFQ.
151	How is AOT plan coordinated with HH today?	Revised Interim Guidance on Health Home Assignment of Persons with Assisted Outpatient Court Orders is available at: http://bi.omh.ny.gov/aot/guidance
152	What are existing outcome metrics used by state to monitor outcomes in members with AOT plans	Current outcome metrics are designed to ensure the state's compliance with the statutorily required annual data submission to the legislature. These requirements are outlined in section 7, lines 1-21 of Kendra's law. AOT related metrics can be found on the OMH website: http://www.omh.ny.gov/omhweb/statistics/index.htm These reports contain general AOT statistics, characteristics of recipients, and recipient outcomes including service participation and social and community functioning.
153	Describe the State's strategy to ensure timely outreach and effective engagement of membership by HHs.	Metrics are being collected and will be available for review by the state and the HARPs. There will be a period of time for the metrics to be shared with each Health Home and quality improvement strategies will be discussed. If necessary, this communication may move to a plan of corrective action. If the Health Home fails to meet its corrective action plan outcomes, other action steps, yet to be determined, will be available to the state and to the HARP.
154	Please provide additional information to help clarify peer support service limits noted at the bottom of pg 124 RFQ?	1915(i) peer support services are limited to 500 hours in a calendar year. A HARP can choose to exceed this limit, although it is not obligated to.
155	For item L. 3. - Can we receive clarity around what financial reports are being referenced? Is	The plan should describe their current process for compliance and how they plan to comply with additional P4P and risk corridor reporting

	the requirement relative to our MMCOR filings?	requirements.
156	Clarity is required for question E23 (page 97), and the issue related to NQTL's associated with network contracting and reimbursement. Please clarify.	Plans are required under federal law and regulation to comply with parity requirements for behavioral health. This question requests that Plans describe their approach to assuring an adequate behavioral health network (including timely access to services) and how they are ensuring parity on quantitative and non-quantitative limits (See 29 C.F.R. Part 2590).
157	The State provides a certified listing of all OMH / OASAS providers. Is that sufficient for credentialing purposes or do we need to obtain the certification / license directly from the provider? (3.7 H, page 59)	An OMH license or OASAS certification will suffice for Plan credentialing purposes. The list provided by the State is sufficient for the initial round of contracting required for this RFQ.
158	Please clarify the language in E26 (page 97), specifically "using tools available to managed care."	NYS is asking Plans to describe how they can use their expertise and the various tools available to manage care (data analytics, contracting, performance measurement, etc.) to collaborate through the RPCs with counties, providers, and consumers to help meet the State's objectives as specified in section 1.7 of the RFQ.
159	RPCs (Regional BH Planning Consortiums): When will the guidelines for the RPCs be developed? In 3.11 C, the document mentions a "Memorandum of Agreement (MOA)" to be signed with the RPCs. When will this be provided? Who will have oversight over the RPCs?	Regional BH planning Consortiums (RPC) are in the process of being developed. They will be comprised of each LGU in a region, and representatives of mental health and substance use disorder service providers, child welfare system, peers, families, Health Home leads, and Medicaid MCOs. The RPC would work closely with State agencies to guide behavioral health policy in the region, problem solve regional service delivery challenges, and recommend provider training topics. A memorandum of agreement will be required to address Plan cooperation and coordination with the RPC in such areas as training, data analysis, and planning.

160	Per paragraph 4.0. proposals should be printed on double-sided paper. The RFQ has page limitations for many of the sections of the response. Given that the document is to be printed double-sided, are these limitations intended to be equivalent to the number of pieces of paper or does each piece of paper represent two pages (e.g., is a two page limit equal to two pieces of paper (front, back, front, and back) or 1 page (front and back)?	Each side of a page is one page.
161	Section 4.0, paragraph A., question 2.d., is this address intended to be the address from which checks/drafts will be sent or to which these items should be sent?	This question asks for the address to which checks/drafts should be sent.
162	Section 4.0, paragraph A., question 3.i.., is there a specific format for this attestation or is it sufficient if the vendor repeats the RFQ requirement (e.g., "no Plan X employee or consultant has ever been debarred, suspended, or excluded from any federal or State program.") and an officer signs and dates that affirmation? The same question applies to Section 4.0, paragraph A., question 14, which also requires a similar attestation.	Yes, it is sufficient that the vendor repeats the RFQ requirement.
163	Section 4.0, paragraph B., question 5., requires an extensive amount of information to support the Plan's proposed staffing, including a rationale for the estimates for each position. This section is limited to two pages. Also, plans proposing the HARP appear to be required to submit a more extensive answer within the same maximum page count. We believe this page limitation is	NYS agrees that this question requires more space. Plans may have up to 4 pages to answer this question (Section 4.0, paragraph B., question 5.)

	insufficient to adequately respond to this requirement, and thus request that the limitation be increased to five pages.	
164	Several sections of the RFQ require that the responder submit customer references that can verify the experience described. If the responder includes a description of experience serving New York members in another publicly funded program, can the responder list an individual from the New York Department of Health (DOH) as the customer reference? If so, is the responder permitted to contact the DOH employee to alert them of their inclusion as a customer reference, or are we prohibited from contacting any personnel of the State other than the RFQ designated contact agent, even in this scenario?	The Plan is free to include a description of experience serving New York as a BHO or serving New York managed care members in another publicly funded program. However, the State does not provide recommendations to applicants in RFQs.
165	Section 3.2 outlines required experience requirements for Plans, and identifies that Plans must demonstrate experience throughout their own organizational experience with specific program or alternatively have the option to demonstrate the required experience through the hiring of experienced staff on a BHO. Please confirm that for questions or portions of questions throughout the RFQ that specifically include language that indicates the response is specific to organizations relying on staff rather than organizational experience to meet the required experience standards, respondent	Plans must respond to all questions as appropriate. If the Plan is using organizational experience to meet the experience requirements of the RFQ then they do not need to answer the questions that are specific to Plans relying on the experience of key and managerial staff.

	Plans with adequate organizational experience are not expected to respond to these questions. Examples of such language can be found in Section 4.0 questions: A.6, A.8, J.2, J.3 of the	
166	Will there be a readiness review for the QHP?	Yes
167	Will the State ensure that an adequate administration (> $6.00 pm/pm) be passed on to a Plan's BHO partner to administer this enhanced scope of work	The administration in the HARP for NYC is close to $185 PMPM. The amount of administration given to the BHO for their work is to be negotiated between the plan and the BHO. NYS will review these agreements. It is the expectation that BHO partners are funded adequately to achieve the outcomes and systems requirements as described in the RFQ.
168	The RFQ asks for the HARP Plan's outreach plan for consumers. So are HARPs permitted to market to recruit members?	Plans operating a HARP are permitted to reach out to their members identified by NYS as HARP eligible and encourage them to enroll in their HARP.
169	What are the Medicaid benefits for members less than 21 in 2015?	The Medicaid benefits for people under 21 do not change in 2015 as a result of this initiative.
170	BHO 1 spoke of high risk population. Is there a state definition of high risk or is it left to each plan to define?	BHO Phase I plans monitored care coordination needs for "Complex Needs" groups that were defined by NYS. In Phase II, Plans are asked to describe what predictive modeling and stratification procedures they will use to identify high-need populations for targeted care management.
171	Is the enrollment broker doing the assessment for 1915(i) the same person as the one directing people to Plans?	Individuals who are not enrolled in a Health Home will have their 1915(i) assessment administered by the enrollment broker. NYS will be providing additional guidance on this subject.
172	Will there be a subsequent readiness review to administer children's benefits in 2016?	No decision has been made at this time. More information will be provided at a later date.
173	Do MCOs that have a HARP get the HARP rate for all HARP eligible members?	The HARP rate is paid only for HARP eligible members enrolled in the Plan's HARP.
174	If a HARP contracts with an IPA, can the plan delegate some of the provider training and oversight responsibilities to the IPA?	NYS is formulating a response to this question and will post the answer as soon as possible.
175	In the Network Management section (E), questions 2 (a) and (b) appear to duplicate	Questions 2(a) and (b) deal with the issues/problems presented by adding a large contingent of new providers serving persons with Serious Mental

	question 7. Can you define any differences in expectations in regards to the response to these questions?	Illness. Your response to question number 7 should simply be a reference to your answer to 2a and expand as necessary.
176	Question L. 4 in section 4.0, states "Applicants must complete financial statements…" and Question L.5 states "Applicants must include the source of any additional capitalization that may be needed to support the new program…", items 4.b, c, and d, and 5 reference the "new program (HARP)". Please confirm if these are HARP only requirements. If these requirements are for both HARP and non-HARP plans, please confirm if you are looking for projected financial statements for L.4. If yes, please provide non-HARP rates to enable plans to create projections and identify any need/source of additional capitalization to support the new program.	Section 4.0 Question L 4a and b are HARP only requirements. Section 4.0 Question L 4c and d applies to the entire MCO operation. Draft rates for the mainstream BH carve-in are under development. However, assuming that all HARP eligibles enroll in HARPs, the data on historical BH spend in the databook for the non-HARP rate cells can be used to project the need for any additional capitalization. The data book will be updated after the preliminary HARP designations are made. Revised calculations for additional capitalization need to be made at that time. The latest databook can be found at: http://www.omh.ny.gov/omhweb/bho/data-book.pdf
177	Can a health Plan initially apply to be a HARP in a limited service area (1 or more counties) and at a later date expand to other service areas (full service area or specific counties)?	At this time the answer is no. However, New York State is considering this request and will provide additional information in the near future.
178	Can the State clarify whether the Substance Use Disorders level of care determinations based on the OASAS LOCADTR tool are for detox units only or does it include acute inpatient medical detox units?	The OASAS LOCADTR tool is required for use in all certified levels of care.

179	Can the State disclose how many of the 130,860 inpatient and detox admissions in CY 2011 were admitted to acute inpatient medical units for withdrawal or medical complications related to detox? Is there a known readmission rate for this segment of the population? Please clarify if the Behavioral Health Medical Director and Behavioral Health Clinical Director are MCO employees or delegated BHO staff.	There is no known readmission rate for this population. The BH Medical Director and Clinical Director may work for either the MCO or the delegated BHO. However, Plans must demonstrate how these key staff as well as other BHO staff will interact with the mainstream Plan to ensure an integrated benefit package and integrated decision making.
180	1.3 v Can the State indicate how incarcerated members with behavioral health conditions will be identified? Can the State indicate the process for obtaining housing for the homeless and what is the wait time? (Medicaid Redesign)	NYS will be working with NYC to develop a process for identifying incarcerated individuals with behavioral health conditions. NYS will also be working with the Conference of Local Mental Hygiene Directors and Sheriffs of upstate counties to develop a similar process for the rest of state. OMH will be working on a process for how Managed Care Plans and Health Homes will access existing housing funded by OMH. There currently exists a referral process as well as single point of access in New York City.
181	1.11Hii How are the managed care efficiencies determined and applied to the rate?	These adjustments were based on Mercer's experience working with other states in implementing BH managed care, as well as changes observed in the management of Acute Care services for HARP populations that transitioned into managed care during the base data time period. Along with other factors, the analysis looked at inpatient readmission rates and average lengths of stay. Mercer also looked at the potential impact of 1915i services and other community services on non-inpatient BH services and reviewed cost statistics for other BH services in NYC and identified areas

		where managed care efficiencies may be feasible. Downward adjustments were applied to the Behavioral Health – Emergency Room line item as well as to certain non-Inpatient services. Upward adjustments were applied to all Community services. Larger increases were applied to Assertive Community Treatment
182	Will the State consider allowing Plans to have one behavioral health advisory subcommittee made up of representatives from each region corresponding with RPCs?	Plans operating in more than two or more RPC regions may suggest alternative arrangements for State approval.
183	3.7 b iii. Can the State please clarify what is meant by "current episodes of care?" Is it different than ongoing treatment? For instance, if an enrollee has been seeing the same physician for years but is not in the middle of an episode but is being treated occasionally, does that count toward a current episode?	For continuity of care purposes Plans must allow members to continue with their care provider for the current episode of care. Episodes of care are determined by Plans based upon a review of medical conditions against State approved UM protocols. Plans may use UM protocols to review duration and intensity of episodes. This requirement will be in place for the first 24 months of the contract. It applies only to episodes of care that were ongoing during the transition period from FFS to managed care.
184	3.7 c iii. Can the State please clarify how it defines "participation?" "The Annual Network Plan will be developed with the participation of consumers, family members/caretakers, providers (including State-operated providers), LGUs and other community stakeholders and be guided by the input/priorities of RPCs."	The Plan shall have a BH advisory subcommittee (for each region corresponding with RPCs) reporting to the MCO's governing board. The subcommittee will include peers, providers, local government and other key stakeholders. Additionally, Plans are required to coordinate training with the regional planning consortiums. RPC membership includes families and peers. Plans should obtain input from these and other sources when developing the network plan.
185	3.8 b ii What does the State mean by "included in the development and delivery of trainings?"	The Plan shall have a BH advisory subcommittee (for each region corresponding with RPCs) reporting to the MCO's governing board. The subcommittee will include peers, providers, local government and other key stakeholders. Additionally, Plans are required to coordinate training with the regional planning consortiums. RPC membership includes families and peers. Plans should obtain input from these and other sources when developing the training plans.
186	SECTION 4.1 ORGANIZATION,	AOT care coordination providers (ACT Teams and Health Home Care

	EXPERIENCE AND PERFORMANCE G. Clinical Management Can the State provide the AOT report requirements?	Managers) must use the Child and Adult Integrated Reporting System (CAIRS) to report on AOT recipients. These providers are required to submit a baseline assessment at the onset of a court order and follow-up assessments at six month intervals and/or at the expiration of the court order in CAIRS.
187	Please confirm that all positions listed in Section 3.3 of the RFQ are considered medical expenses.	These are Plan staffing requirements and are administrative costs.
188	RFQ states "NYS will provide guidance on 1915(i) services and will designate providers that meet 1915(i) qualifications. As this information is critical, is there a date when this guidance can be expected?	NYS is working on this as quickly as possible.
189	Will we be making our initial HARP Network Adequacy submission through the PNDS via the HCS portal? If so, when will the submission be open and available to us for testing through the PNDS system?	Yes, network information will be submitted through PNDS. Testing may begin by mid-August 2014.
190	If we are making our initial HARP Network Adequacy submission through the PNDS system will the template currently used for other lines of business be the same as for HARP, or will the template be updated? If so, when can we expect a new template?	The current template will continue to be used.
191	*RFQ S*tates "Plans must conduct geographic access analyses …" Will a template be provided for the submission of time and distance standards? If so, when will it be provided?	We are not anticipating that there will be a geographic access analysis template. NYS will continue using the existing process.
192	Are we to submit the time and distance analysis at the same time we submit the Network Adequacy submission?	Yes
193	*RFQ* states "*Plans must submit a detailed*	This is correct. A listing of providers and explanation of how it meets

	network plan for review and approval as part of the required implementation plan outlined in Section 3.18 of the RFQ at least 120 days prior to the start-up date". Subsection i. states *"A listing of providers and explanation of how it meets network adequacy standards".* Given that we implement on January 1st, does this mean September 2nd (120 days prior to implementation) is the deadline for our Network Adequacy submission?	Network Adequacy Standards must be submitted by September 2nd.
194	Is a HARP expected to be structured as a separate entity from the mainstream QHP, requiring new contracting with the existing mainstream plan's provider network?	Yes, a HARP is a separate line of business. Separate contracts for HARP providers will be required.
195	Is a separate Data Book being prepared for the HIV SNPs?	No, one all-inclusive data book was created. Based on information in the data book, an HIV SNP HARP rate was created.
196	If a HARP plan uses a Behavioral Health Organization (BHO), is the BHO expected to contract with Health Homes or is it the HARP plan that must contract with a Health Home?	The HARP needs to contract with the Health Home. If the HARP wants to propose an alternative arrangement, they must submit this proposal to NYS for review and approval.
197	Health Insurer Fee: Most HARP eligible members were in mainstream managed care in 2013. How does DOH plan to incorporate the ACA Health Insurer Fee into the HARP premium for the portion of the fee applicable to 2013 premiums received for these members?	DOH will make all the necessary adjustments. If the tax is applicable to the Plan, there will be a reconciliation based on the actual tax paid by the Plan relative to mainstream and HARP enrollment.
198	Program Changes: The state indicates it will make adjustments to the base data for program and benefit differences. In addition to changing the IP Pysch days limit, please list the benefit changes in years 1-3 and their impacts.	No additional program and benefit changes are contemplated beyond those already discussed. These include rehabilitation services for residents of community residences, psychiatric inpatient stop-loss, and 1915(i) services.

199	Will the State allow attachments to be added, other than those mandated by the RFQ, that do not count in the page limitation. • For example, we would give a brief description of the Bridge Program (few sentences for goals and process and accrual improvement in HEDIS measures as outcomes). Then attach a program description to the response as an attachment. Another example for a response with a one page limitation, add a workflow or an org chart as an attachment to further illustrate the written description.	Not unless attachments are specifically allowed in the RFQ or newly allowed in another FAQ answer.
200	**Section 3.5.G, Table 4** Where Table 4 refers to days, is it referring to business days or calendar days?	The appointment availability standards in Table 4 refer to calendar days.
201	Please confirm changes to IMD disenrollment criteria. Our areas of question are below. 1. IMD stays for HARPs and other consumers will be billed FFS 2. No IMD exclusions, v disenrollment's regardless of LOS 3. Plans are responsible for transitions and post dc engagement 4. IMDs will be required to notify plans of admission	1. At this time MCOs (including HARPs) will not be required to pay OMH for any psychiatric inpatient care provided to adults, under 65, in any of its psychiatric centers. MCOs MAY use free-standing, private psychiatric hospitals (which are IMDs), and will be obliged to pay for such care based on in-network agreements or their out-of-network liability. 2. Per 1 above, OMH is excluded. Other psychiatric hospitals are not excluded. MMC/HARP admissions to OMH will be disenrolled from MMC/HARPs after "X" continuous days of inpatient care in OMH. Individuals discharged within 90 days of admissions will automatically be reenrolled in their previous MMC/HARP, but have the opportunity to change plans at that time.

		3. For individuals still enrolled in the Plan after a stay in OMH, the plans are responsible for transitions and post discharge engagement. The same will apply to individuals who will be automatically re-enrolled in the same plan. The plans will not be responsible for transition for individuals disenrolled from the plan who indicate a desire to enroll with another plan. 4. IMDs will be required to notify Plans of admission. NYS will be requiring that plans NOT penalize IMDs (and other psychiatric inpatient providers) that do not notify plans of an admission within the expected time when the patient's condition and absence of a patient representative makes it impossible to determine with whom the patient is insured.
202	Is training available on AOT process and requirements for plans and HHs	Plans and HH's should familiarize themselves with AOT by reviewing the information available at: http://bi.omh.ny.gov/aot/about Training for Plans and Health Homes will be arranged in the near future, likely in the form of a webinar.
203	When will the timeframe be determined for how long the Plan will have to notify the member of health home eligibility? (Pg. 67, K ii)	This will be determined as part of the broader Health Home/HARP roles and responsibilities discussion.
204	What are the intentions in terms of the timeframe for including the health home payment in the premium? (1.11 E, page 22)	Funding for Health Homes are not included in the preliminary premiums. Funding for Health Homes will be paid by the State to the Health Plans either as a pass through or in the capitation.
205	Provider Profiling: How is this going to be done in collaboration with other health plans to	NYS will review Plan responses. Based upon the responses, the State may decide to work with Plans and the Plan Association to develop a common

	ensure uniformity, and not generate additional administrative costs across the Health Plans? (3.7I iv, pg. 59; p 67; E17, pg. 96)	approach.
206	Given multiple health plans participation, is there any consideration being given to develop training materials collaboratively amongst health plans in an effort to reduce redundancy of training for health homes? (Page 61, 3.8 Di) 1. The Health Plans are being asked to develop a plan to assist Health Homes in staff development, including recruitment, training, and overseeing qualified staff to conduct functional assessments. For Health homes that contract with multiple plans, provide a proposal for collaborating across plans to avoid duplicate or conflicting requirements. (G17, Pg. 104)	This is not an RFQ question. However, whenever possible, training and education for providers and Health Homes should be provided in coordination with the Regional Planning Consortiums (RPCs). In NYC, this function will likely be managed by the NYC Department of Health and Mental Hygiene.
207	Can you please specify which benefits coming into Mainstream Plans will be required to pay Medicaid FFS rates? Meaning is there a specific list of benefits that can be identified and the rates that are required to be paid to the providers?	Government rates apply to all ambulatory services licensed/certified/designated by OMH or OASAS. All Medicaid Fee for Services rates for OMH and OASAS services can be found on their respective websites: http://www.omh.ny.gov/omhweb/medicaid_reimbursement/ http://www.oasas.ny.gov/admin/hcf/APG/Index.cfm
208	Will the 1.5% start up premium be included in future year premiums or should rates be discounted when building financial forecasts.	NYS is allowing 1.5% of the premium to be used for start-up. In future years these funds will be applied to pay for performance bonus pools.
209	HARP eligible members that choose not to enroll in HARP, will there be an enhanced rate for the members in QHP?	The mainstream rate will be adjusted for the possibility that some MCOs did not qualify as HARPs and some HARP-eligibles might not join a HARP. There will not be an enhanced mainstream rate for individual

		HARP eligibles who do not enroll into a HARP.