

Behavioral Health Organization (BHO) Selection Process Document

Questions and Answers

July 15, 2011

Updated 7/26/2011 to address questions 100 & 128.

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BHO Scope of Work

- 1. The RFP calls for the bidder to have inpatient admission criteria. In the event that an admission fails to meet admission criteria and felt to be inappropriate, what is OMH's expectation of the BHO in terms of managing this situation? Will the BHO "deny" such an admission on behalf of OMH?**

Answer: The BHO does not approve or deny admissions to inpatient settings. As stated in 10.1.1.6:

When the BHO concludes that continued inpatient treatment is no longer necessary, it will inform the inpatient provider of such conclusion, provided however that the provider may document to the BHO reasons why such provider believes continued inpatient treatment is warranted and request review of the initial determination by the BHO's senior clinician. If the provider fails to discharge the patient within 48 hours of being notified of such determination, the BHO will generate a formal notice of clinical determination. This will be sent to the provider and to The Offices.

The procurement requires applicants to describe the mechanism for assessing the appropriateness of inpatient level of care on initial and concurrent review including (but not limited to) clinical domains a through d, below. Wherever possible, the Applicant should describe scales, assessment tools or scoring mechanisms used to determine inpatient level of care appropriateness including:

- DSM-IV or V Axis Diagnosis
 - Rationale for necessity of Inpatient Level of Care:
 - Suicide risk assessment
 - Potential for violence or danger to others
 - Inability to live safely within the community due to acute psychiatric symptoms
 - Active Treatment and Discharge Planning
 - Pharmacologic:
 - Psychosocial
 - Substance use
 - Housing Status
- 2. RFP Section X, Required Tasks, 10.1.1.4, page 14. The RFP states "The BHO will determine the intervals for such subsequent discussions and the criteria for determining the appropriateness of continued inpatient care." If the BHO determines that continued inpatient care is not appropriate or medically necessary, does the BHO administer a denial? If so, what is the procedure for issuing a denial? Is there an appeal procedure?**

Answer: The BHO does not approve or deny admissions to inpatient settings. As stated in 10.1.1.6:

When the BHO concludes that continued inpatient treatment is no longer necessary, it will inform the inpatient provider of such conclusion, provided however that the provider

may document to the BHO reasons why such provider believes continued inpatient treatment is warranted and request review of the initial determination by the BHO's senior clinician. If the provider fails to discharge the patient within 48 hours of being notified of such determination, the BHO will generate a formal notice of clinical determination. This will be sent to the provider and to The Offices.

The procurement requires applicants to describe the mechanism for assessing the appropriateness of inpatient level of care on initial and concurrent review including (but not limited to) clinical domains a through d, below. Wherever possible, the Applicant should describe scales, assessment tools or scoring mechanisms used to determine inpatient level of care appropriateness including:

- a. DSM-IV or V Axis Diagnosis
 - b. Rationale for necessity of Inpatient Level of Care:
 - iv. Suicide risk assessment
 - v. Potential for violence or danger to others
 - vi. Inability to live safely within the community due to acute psychiatric symptoms
 - c. Active Treatment and Discharge Planning
 - iv. Pharmacologic:
 - v. Psychosocial
 - vi. Substance use
 - d. Housing Status
3. **If BHO determines that there is not medical necessity for continued, prospective treatment but the recipient is court mandated for treatment, how should the BHO best document that the remaining days are only being covered due to the court mandate?**

Answer: A court-ordered retention is a determination at the time of the issuance of the order that the condition of the individual warrants a continued stay in the hospital for up to a given period of time. It is not a determination that the individual must remain in the hospital for the full time of the order. If during the period covered by the order the individual's condition improves to the point where continued inpatient care is no longer necessary, then the individual may and should be discharged. Accordingly, the BHO should review the continued need for inpatient treatment for these individuals based upon clinical criteria to be approved by the Offices. If the stay does not meet the continued need criteria, the BHO will send a notice of clinical determination to the provider. The provider must be given an opportunity to tell the BHO reasons why such provider believes continued inpatient treatment is warranted and this may include continued treatment under a court mandate. For children with SED, court ordered assessments (251 orders) are not Medicaid billable, thus would not be tracked by the BHO. Court ordered placements are rare and for purposes of the BHO would not be considered acute admissions.

4. **Does the BHO directly work with Medicaid members or only work directly with providers and thus indirectly with Medicaid members?**

Answer: The Offices anticipate that the BHO will work with providers and Medicaid Managed Care companies and not recipients of services. However, all options will be considered.

5. **Can the RBHO speak directly with members they are facilitating care for in an effort to support aftercare planning and engagement?**

Answer: The Offices anticipate that the BHO will work with providers and Medicaid Managed Care companies and not recipients of services. However, all options will be considered.

6. **Selection Process Document Instructions – Please confirm whether or not the BHO will be able to directly contact members as part of the required tasks in Section X.**

Answer: The Offices anticipate that the BHO will work with providers and Medicaid Managed Care companies and not recipients of services. However, all options will be considered.

7. **In "profiling provider performance," does the term, "provider," mean individual practitioner, facility, and/or both?**

Answer: The term provider refers to facilities or agencies licensed or funded by Medicaid, OMH, or OASAS. It does not refer to individual practitioners.

8. **Item 11.2 - Is this review for the inpatient users within the RBHO initiative, or prior failures?**

Answer: Section XVII(A)(6)(6.2)(11.2) reads "Please address your capability to assess the reasons why people discharged from behavioral health inpatient settings did not engage in outpatient care post discharge. Please also address your capability to identify this population of individuals and attempt to engage them in care."

This section relates to inpatient users that have been identified by OASAS and OMH or the BHO as not engaging in post discharge outpatient care.

9. **If BHO identifies a recipient who is not engaging in outpatient care, can a RBHO staff person conduct outreach and engagement activities directly? (i.e. w/the recipient)**

Answer: All options will be evaluated. Required tasks must stay within the budget parameters listed on page 27 of the solicitation document.

10. With respect to Section 10.1.2.1 (p. 14), it says that “the BHO will employ enhanced engagement efforts” with designated high need populations. Is it within the scope of the Required Services for an applicant to hire staff to work directly with the designated hard to engage consumers and providers in order to facilitate engagement in outpatient services? In other words, is the BHO permitted to directly provide “high touch” services to the most difficult to engage cohort of the FFS population? If not, how is OMH contemplating that the BHO provide “enhanced engagement efforts”? Additionally, if the BHO is permitted to provide direct consumer services, can the BHO also subcontract for these enhanced engagement services with OMH/OASAS approval?

Answer: All options will be evaluated but no subcontracts are allowed without the written approval of OMH and OASAS. Required tasks must stay within the budget parameters listed on page 27 of the solicitation document

11. Does your response apply only to people who are admitted to inpatient after 10/1/11 or 1/1/12 (three months after the contract date)?

Answer: The BHO's responsibilities begin with people admitted or readmitted on or after the implementation date of the contract. However, completion of the required tasks requires the BHO to look at past history prior to the start of the contract.

12. RFP Section X, Required Tasks, 10.1.1.3, page 13. The RFP states: "For each such admission, within 48-72 hours after admission, the BHO will contact the provider...for the purpose of assessing the appropriateness of continuing inpatient care for longer stay individuals." Will this review for medical necessity be purely prospective (e.g., determining if future days are warranted)? Or will it also be retrospective to determine if the admission itself is warranted?

Answer: The BHO will conduct prospective reviews. They will not review the determination to admit in the first place.

13. For Task 4, 10.4.4, what is the scope of responsibility of the BHO to "facilitate linkage to physical health"? Do OMH/OASAS consider it within the scope of service for the BHO to provide "high touch" care management for the most high need, disengaged populations to increase likelihood that they receive medical services, or is it envisioned to be solely the responsibility of providers, MMC plans and Health Homes?

Answer: In general, this relates to coordinating with Medicaid managed care companies to facilitate access to care and coordinated care for high needs high cost individuals with physical health needs that are in or have been discharged from

behavioral health inpatient settings. All options will be evaluated but no subcontracts are allowed without the written approval of OMH and OASAS. Required tasks must stay within the budget parameters listed on page 27 of the solicitation document.

- 14. 10.1.2 Monitor discharge planning activities and facilitate timely connection to services post discharge. 10.1.2.1, Page 14. “The BHO will engage with the inpatient unit with regard to discharge planning for all covered behavioral health admissions. Activities for this task vary by type of population. The BHO will employ enhanced engagement efforts for those individuals who are admitted and have been identified by the State as high need individuals disengaged from ambulatory care, and for people who are readmitted within 30 days of a prior discharge for psychiatric care and 45 days for substance abuse treatment. The purpose of the enhanced engagement efforts is to improve ambulatory contact after discharge.” Please confirm whether the Offices will allow the BHO to have direct contact with members as part of enhanced engagement efforts?**

Answer: The Offices anticipate that the BHO will work with providers and Medicaid Managed Care companies and not recipients of services. However, all options will be considered.

- 15. RFP Section X, Required Tasks, 10.1.2.2.1, page 14. What ASAM.PPC- 2R Levels of Care (e.g., Level 111.7) are the OASAS certified 816 inpatient detoxification and OASAS certified PART 818 inpatient rehabilitation programs equivalent to?**

Answer: Part 816 is Level IV-D and Part 818 is Level IV.

- 16. Will OMH provide a letter template for use by RBHOs to use to notifications to inpatient providers of findings of care not meeting level of care?**

Answer: No.

- 17. Will enrollees need to be notified of above determination?**

Answer: No.

- 18. RFP Section 10.1.1.6 – Notifications of clinical determinations that continued care is unnecessary will be sent to the provider and The Offices. In these instances are consumers notified and do they have any due process opportunities?**

Answer: No. Consumers are not notified by the BHOs. Providers must be able to speak to BHO clinical staff but since the BHO is not a payer and the BHO has no authority to pre-approve or disallow services, there is no consumer appeals process.

19. **RFP Section X, Required Tasks, 10.1.1.5, page 14. The RFP states "For Chemical Dependence Inpatient Rehabilitation, the BHO will review the need for continued stay within 21 days to ensure that the patient meets criteria for continued stay." If the initial review is done on day 20, for example, is the review for the entire stay or just day 20 and forward?**

Answer: The review is for day 20 and forward.

20. **Will the State market services or will contractors be expected to provide all marketing initiatives?**

Answer: While not marketing in the usual sense, the Offices will inform inpatient providers of the obligation to report admissions to the BHO selected for each region. The successful bidder will be expected to communicate with the hospitals and other stakeholders in the region to establish working relationships and clarify procedures for information exchange.

21. **RFP Section 10.1.1.3 – Do The Offices anticipate that concurrent reviews will be conducted telephonically or on site?**

Answer: The Offices anticipate that concurrent reviews will be done telephonically.

22. **RFP Section 10.4.1 – Do The Offices see coordination as general in nature or specific to the coordination of care for individuals?**

Answer: The BHO monitors inpatient usage and discharge planning on an individual basis and for every Medicaid fee-for-service individual admitted to or discharged from a covered inpatient setting.

23. **RFP Section XII – The RFP requires that the Project Director be located in the BHO's region and requires that licensed and credentialed clinical be proposed. Can concurrent reviews be conducted by clinical staff licensed in another state?**

Answer: Concurrent reviews can be conducted by staff located in New York or in other states but they must be appropriately licensed/credentialed and have an understanding of the New York State behavioral health system in the region.

24. **Are there any separate processes or requirements for the BHO related to the BH services provided to members on a forensic basis?**

Answer: There are no separate processes for forensic populations.

25. **Will the Offices take any particular action with the provider, if a provider fails to discharge a member within 48 hours of being notified by the BHO that inpatient treatment is no longer necessary? For example, will payment to the provider be discontinued for that member for the "no longer necessary" days of treatment?**

Answer: The BHO will issue a formal notice of clinical determination that the hospital has not demonstrated the need for continued stay. The Offices reserve the right to take action against any provider they license. Payment will not be discontinued although all payments to providers are subject to audits and providers will need to be able to demonstrate medical necessity.

26. Section X: Scope of Work. Can the BHO review Chemical Dependence Inpatient Rehabilitation stays before 21 days?

Answer: Yes. The review must occur within 21 days meaning it can occur before the 21st day.

27. Can the BHO issue a determination letter on day one if they believe that the member never needed to be admitted?

Answer: The BHO does not review the decision to admit. However, if the BHO determines that there is no need for continued stay, a notice of clinical determination may be issued any time such determination is made.

28. Should the consumer get a copy of the determination letter?

Answer: The BHO is only required to send the Notice of Clinical Determination to the provider and the Offices.

29. RFP Section XII.A.5 Staffing Requirements, page 20. Sufficient and appropriate call center capacity is required. Please confirm that 24/7 call center operations are not required.

Answer: 24/7 capacity is not required.

30. What type of After-Hours and weekend coverage will be expected of the RBHO's?

Answer: The BHO must have a mechanism for receiving provider notification of admission within 24 hours of admission but the BHO is only required to have live coverage during normal business hours, 8 a.m. to 6 p.m. After hours, weekends and holiday staffing and coverage will be considered in making awards. The BHO must contact the provider within 48-72 hours after admission.

31. Will the RBHOs be expected to establish a 1-800# to facilitate their obligations?

Answer: The applicant's response should tell the Office's how they will meet their obligations.

32. Selection Process Document Instructions X BHO Scope of Work 10.1.1.6 – page 14 – How is the formal notice of clinical determination to be formatted and transmitted to the provider and The Offices?

Answer: The applicant's response should tell the Office's how they will meet their obligations.

33. Can the BHO recommend to The Offices additional individuals based on data analysis to be added to that list? Is membership on that list permanent or variable?

Answer: Membership on the list of high needs individuals will be reevaluated and updated by the state every month on a rolling basis. People who do not qualify will be no longer identified. The applicant can offer additional criteria or methods for identifying high needs high cost individuals in their responses. If the BHO believes that they have identified a mechanism for identifying high needs high cost individuals not on the list, they should contact the Offices at that time for discussion. The State will also consult with the BHOs on the definition of the high need/ineffectively engage cohort in year 2 of the project.

34. If the BHO issues a medical determination to the provider that I/P stay is no longer medically necessary and an adverse outcome occurs post d/c what is the inherent liability of the BHO if its status is also a provider of clinical services and not an insurer?

Answer: Issues of an individual entity's liability based upon its status as a provider or BHO should be discussed with the entity's counsel. In general, the BHO role is neither that of a payor or provider of services. The role of the hospital is that of a provider of service which is charged with the legal responsibility of exercising its clinical judgment in a way that is consistent with applicable standards of care.

Additional Capabilities

35. RFP Sections XVII.3.i and XVII.6.2.A, pages 25 and 31. The qualifications and experience question on page 25 asks for the applicant to submit their "experience for Additional Capabilities...Page 31, regarding Additional Capabilities, again requests that the applicant's "experience performing similar tasks..." Given the page limits, should this experience be described twice or included only in the specific capability questions?

Answer: This information should be summarized in XVII.3 and elaborated on as appropriate in XVII.6.2 A.

Budget

36. Are the "Expected Budget Parameters" listed on page 27 annual or for the entire 2 year project term?

Answer: The budget parameters are annual.

37. RFP Appendix B. The BHO Budget Worksheet appears to have two separate spreadsheets that will arrive at the same total, with one spreadsheet associated with the required tasks and one by function. Is this correct? Should the sum of the two separate tabs in the document have the same total? Should only salary and salary related costs be completed in the tabs titled PS by Task and PS by Function?

Answer: Yes this is correct. The two separate tabs should have the same total which should include salary and fringe.

38. Appendix B. Are the three sheet tabs (PS by Task, PS by Function, NPS by Function) independent of each other, i.e., information presented on one will not be part of another (for example, dollars for clinical supervision would not appear both on tab PS by Task and PS by Function)? Asked another way, is the total of the three sheet tabs equal to the grand total of the bid?

Answer: PS by task and PS by function break the same total down in different ways. The PS total plus the NPS total should equal the total budget.

39. Page 26, #4 - Should the Budget Appendices B and B 1 be included in the proposal response, included as attachments or submitted separately? If they are to be included in the document, do they count towards the 50 page limit? If they are to be submitted separately from the proposal response and attachments, should each region be sealed separately or submitted together?

Answer: All documents should be submitted together. The attachments are not part of the 50 page limit. Appendices are considered attachments.

40. In the budget worksheet, there are no IT Support line items for Tasks 1 and 2; however, deliverables are required for these tasks. How should these costs be reflected on the BHO Budget Worksheets?

Answer: This is an error. The budget worksheet has been corrected and a new version is [available on the website](#).

41. Appendix E reflects reporting deliverables for all four tasks but the BHO Budget Worksheets only request "Analysis and Reporting" detail for Task 2. How should the costs for Tasks 1, 3, and 4 be reflected on the BHO Budget Worksheets?

Answer: This is an error. The budget worksheet has been corrected and a new version is [available on the website](#).

42. The BHO Quality Assurance program is a major scope of work in the RFP, but is not organized under Tasks 1-4 in that document. Since the budget worksheets are organized by Tasks 1-4, does the State have a preference for where in the budget worksheets to place the costs for the Quality Assurance program, or should the

bidder categorize the Quality Assurance costs into those tasks it expects them to relate to?

Answer: While a quality assurance plan is not required in the solicitation, applicants must describe how they will complete and staff each task. This should include a discussion of quality assurance if relevant. Where a Quality Assurance function is part of the task, the cost should be reflected in the budget associated with that task.

**43. Selection Process Document Instructions – Section A. Submission Requirements
4. Budget – Pages 26 & 27 – Please confirm that each region requires a separate Appendix B, Operating Budget Form from the BHO for each region on which they are bidding.**

Answer: Each region requires separate proposals and budget documents.

44. Selection Process Document Instructions XVII.BHO Development & Submission Requirements A. 4. Budget – Pages 15, 16, 26 & 27 – Please confirm that it is allowable to include pay for performance for enhanced activities for the State identified subset of individuals.

Answer: Required tasks will not be reimbursed on a pay for performance basis.

Data Book

45. Data Tables. Is all the activity displayed in the data tables applicable to this program, i.e., all represented historical activity will fall under the new BHO contract?

Answer: Yes

46. Data Tables. Are the Mental Health tables (Tables 1 through 7) totally independent of the OASAS Detox tables (Tables 8 through 17)? Please verify that information displayed in tables 1 – 7 is not also a part of tables 8 – 17, and vice-versa.

Answer: There is the potential for overlap in populations represented in the mental health and OASAS tables but there is no duplication between the mental health admission, detox admission and inpatient rehabilitation admission counts.

47. Data Tables. There is no “Other” line item at the end of the tables. Do these tables represent a complete listing of, for example, every admission? Can we assume, for example, every hospital that experienced an admission is listed in the table? If not, can you estimate how much activity is missing (e.g., 5%, 10%)?

Answer: The admissions represented in the data tables are Medicaid fee-for-service admissions for calendar year 2009 excluding admissions of individuals who are

enrollees of both Medicaid and Medicare. The data includes all such admissions to the named hospitals that were discharged by 3/31/10.

48. RFP Section 10.1.2.1 – and Table 7 (from the Data Book) – How are high need/unengaged individuals defined?

Answer: Please see the [summary description](#).

49. Data Book – Tables 1, 3, 4, 6, 7, 8, 10, 12, 14, 16 & 17. Please provide, as noted below, the historic annual trend for the most recent two years for the following?

- a. **Mental Health inpatient admissions and length of stay by age group and region**
- b. **Mental health inpatient admissions and length of stay to OMH operated hospitals for children by region and hospital**
- c. **Mental health readmissions within 30 Days by age group and region**
- d. **Mental health outpatient service receipt within seven days of discharge from a mental health inpatient episode by age group and region**
- e. **Mental health high need/ineffectively engaged Individuals by age group and region**
- f. **OASAS detox admissions and length of stay by region**
- g. **OASAS detox readmissions within 45 days by region**
- h. **OASAS inpatient rehabilitation readmissions within 45 days by region**
- i. **OASAS continuity of care within 14 days of discharge for detox and inpatient rehabilitation by region**
- j. **OASAS recipients with 3 or more detox admissions by region**

Answer: The data in the databook is what is available at this time.

Evaluation Criteria

50. p. 32, XVIII. Review and Selection Criteria. May we have further clarification of the Evaluation Criteria for the BHOs? For example, will the Operating Budget Form response weigh more heavily than the Narrative response during The Offices' evaluation? What specific criteria will determine the assignment of a BHO to each region (i.e., Bidder preference, historical operations)? Will The Offices be willing to provide Bidders with the points system, evaluation criteria or other factors or weights?

Answer: The Commissioners of the Offices will select the applicant in each region that they determine to be best suited to provide the services described in the Selection Process Document Instructions, as detailed in Section XVIII of that document.

51. Selection Process Document Instructions XVIII. Review and Selection – Pages 32-33 – Please discuss the weighting of cost and technical scoring in the selection process?

Answer: The Offices will not be releasing the evaluation methodology. The Commissioners of the Offices will select the applicant in each region that they determine to be best suited to provide the services described in the Selection Process Document Instructions, as detailed in Section XVIII of that document.

52. Will the Offices be releasing the scoring methodology for the applicant selection (weights, etc.)? If so, when/where will they be posted?

Answer: The Offices will not be releasing the evaluation methodology. The Commissioners of the Offices will select the applicant in each region that they determine to be best suited to provide the services described in the Selection Process Document Instructions, as detailed in Section XVIII of that document.

General

53. Is the information requested in Section 3.b.ii an allowable attachment?

Answer: An attachment is allowable for Section XVII (A)(3)(b)(ii) reading “For the Applicant’s corporate parents, list the names and percentage of time dedicated to the BHO for the following positions: Chief Executive Officer, Medical Director, Chief Financial Officer, Services Director, Utilization Review Director, Senior Quality Improvement Director, Management Information System Director, and any other senior management or key operational position.”

54. RFP Response Section 5 Implementation Plan - is this an allowable attachment?

Answer: An attachment is not allowable for the section reading “For each required task in this scope of work, please provide an implementation plan that discusses the key steps necessary to become operational, key staff required, and the timeline for implementation.”

55. Is Level of Care Criteria / Standards of Care an allowable attachment?

Answer: An attachment is allowable for Section XVII(A)(6)(6.1)(10.1)(D) for the portion of the text that reads “Wherever possible, the Applicant should describe scales, assessment tools or scoring mechanisms used to determine inpatient level of care appropriateness”

56. Section XIII describes the requirement for a BHO Quality Assurance Program, and it is stated that "the design of the QA program will be subject to OMH and OASAS approval." Is the QA program design to be included in the response?

Answer: A Quality Assurance plan is not required in the solicitation. Applicants must, however, describe how they will complete and staff each task. This should include a discussion of quality assurance if relevant.

57. Is the 3-page Executive Summary included in the 50 page limit?

Answer: Yes, the 3 page Executive Summary is included in the 50 page limit.

58. Can two organizations with complementary expertise and clear management accountability per the RFP form a joint venture to apply?

Answer: As long as the applicant meets the requirements in the selection document, there is no restriction on organization structure.

59. Is OMH/OASAS considering providers as eligible bidders or only MBHO's?

Answer: As long as the applicant meets the requirements in the selection document, there is no restriction on organizational structure.

60. RFP Section, XVII.A, Submission Instructions, pages 24 and 25. The RFP indicates that the proposal font size shall be no smaller than 12 points. Can the text in the question boxes and graphics including tables and diagrams be in a 9 point font?

Answer: The font size shall be no smaller than 12 point.

61. Does the 50 page limit exclude the Executive Summary (three pages), Title Page, and Table of Contents? Is the Budget (Appendix B and Appendix B1) included in the 50-page limit?

Answer: Except for the Appendices, these are all included in the 50 page limit. The appendices are outside the 50 page limit.

62. RFP Section XVII.A, Submission Instructions, pages 24 and 25(Amended). Does the 50-page limit exclude the Implementation Plan?

Answer: The implementation plan is included in the 50 page limit.

63. The RFP states that the files on the USB device need to be protected. Is your preference to have the proposal files encrypted or password protected?

Answer: The protection requirement refers to the formatting and content of the document. It is intended to prevent any changes to the original once submitted.

64. Do you require applicants to duplicate the RFP question before answering each item?

Answer: No but section numbering must be accurate and each question must be answered.

65. RFP Section XVII, 6.1, Requirement 10.1.2.B.a, page 29. Please clarify, "standards of care," Does this refer to Clinical Practice Guidelines, Regional Standards of Care, or other?

Answer: This section refers to the applicant's proposed clinical guidelines.

66. p. 24, Section XVI. Timeframe for Implementation. Please define what is meant in Section XVI regarding "applicants must be fully operational by three months after the date of the signed contract" and how this relates to the October 1st go-live date. Please clarify the go live date. Will the selected Contractor be expected to implement servicing this contract beginning October 1, 2011 or January 1, 2012?

Answer: Applicants will need to be fully operational three months after the date of the signed contracts. Applicant's responses will need to tell the Offices what they can achieve during the implementation period. The Offices' are looking to be fully operational as soon as possible.

67. Are there particular assessment tools that the offices would like to see the BHO use, such as the LOCUS, CALOCUS, AC-OK, etc.?

Answer: There are no specific assessments tools required or expected. The Offices are asking for your expertise.

68. General: Please describe The Offices expectations for criteria, e.g., should bidders propose specific criteria or has consideration been given to New York or national standard criteria?

Answer: Bidders should propose criteria. The Offices are asking for your expertise.

69. RFP Section V.3 – Some links seem to be broken. Can the State confirm and provide referenced documents independently?

Answer: All of the links work when the selection process document is opened within a web browser. If the browser opens the selection process document as a separate Acrobat file, the links may not work. In either case, all the documents necessary for the procurement can be found on the [OMH website](#).

70. In the cost proposal, what is the difference between "PS by Task" and "PS by Function?" Are the totals for each supposed to equal each other?

Answer: PS by Task and PS by Function present the same total PS costs, but sorted differently.

71. On the “PS by Function”, why is “Information Technology” listed as both Task 3 and Task 4?

Answer: This is an error. The budget worksheet has been corrected and a new version is [available on the OMH website](#).

72. Please confirm that corporate overhead expenses should be included in section C of the “NPS by Function” tab of the cost proposal.

Answer: Yes.

73. Please provide specifics on what should be included in the budget narrative.

Answer: The budget narrative is the applicant's opportunity to explain what assumptions were used to estimate the costs presented in Appendix B: Operating Budget Forms and how these costs support the proposal's objectives.

For example, if the NPS worksheet includes an amount for travel costs, the budget narrative would explain the assumptions used to estimate the travel costs (how many staff would be traveling, where they would be traveling, the roundtrip airfare, train fare or mileage costs, hotel, meals, etc.) and how the travel would help the applicant accomplish the required tasks.

74. On the “NPS by Function” tab of the cost proposal, note 5 asks to “provide detail.” Please provide specific on what detail is needed.

Answer: Note 5 is asking for an explanation of the rate used to calculate corporate expenses. This should also be explained in the Budget Narrative. See the revised worksheet [available on the OMH website](#).

75. Please describe how each type of inpatient psychiatric and inpatient substance use services are reimbursed, such as DRG, Case Rate, PIP etc.

Answer:

- All fee for service admissions to OMH-licensed psychiatric units (all ages) in general hospitals (Article 28 hospitals) are reimbursed on a fee-for-service per diem basis.
- All fee for service children and youth admitted to OMH licensed psychiatric hospitals (Article 31 hospitals) are reimbursed on a fee-for service per diem basis.
- All Fee for service children and youth direct admissions (i.e., not transfers) to OMH State operated children’s psychiatric centers or children’s units of psychiatric centers are reimbursed on a fee-for service per diem basis.

- All Fee-for-service OASAS certified hospital (Art 28/32) or freestanding (Article 32 only) Part 818 Chemical Dependence Inpatient Rehabilitation Services covered by this solicitation are reimbursed on a fee-for-service cost based per diem basis, except for State Operated facilities which are reimbursed on a Fee-for-service Statewide per diem basis.
- All Fee for service OASAS Certified Part 816 Inpatient Detoxification Services (Article 28/32) covered by this solicitation are reimbursed on a provider specific fee-for-service per diem basis.
- Medicaid fee-for-service episodes in all OMH licensed psychiatric inpatient programs and OMH operated psychiatric hospitals were in 2009 reimbursed on a constant per diem basis, unless the patient was determined to require an “alternative level of care” during the inpatient episode.

76. Can you clarify the following language in Section IX “BHO regions” (p.12): “...applicants choosing to bid on more than 1 region are asked to rank the regions in order of importance.” If Organization A forms a joint venture in a region with Organization B, and the A-B joint venture legal entity is the applicant, does Organization A have to designate a preference if Organization A participates in a joint venture with Organization Z, and A-Z joint venture legal entity applies in a different region? The applicants would be distinct legal entities with 1 common participating organization.

Answer: For this purpose, the bidder’s application must identify who is the prime entity on the contract. If an organization is the prime on applications for more than one region, they must provide a ranking. The Offices prefer to make the five awards to five different applicants. The Offices consider a joint venture including a corporate entity that is also submitting another sole application for another region to be the second submission by the corporation. Therefore, the corporation with two submissions must indicate its regional ranking.

77. Will the Offices be releasing a list of the Bidders’ Conference attendees? If so, when/where?

Answer: The Offices will release a list of organizations attending the bidder’s conference that indicated they were potential bidders.

78. Does the selection as the regional BHO for phase I imply automatic continuation as the regional BHO for phase II? Or would procurement for phase II be opened up to another competitive process?

Answer: Selection for phase I does not guarantee that the awarded applicant will be selected for phase II. Phase II will be a separate process.

79. Please clarify: “The anticipated length of the project is two years. The term of any contract awarded shall be for one year with the option to renew for up to four

more years, subject to available funding”. Is this saying the contract term will be for 2 years or 1-5 years?

Answer: The contract will be a one year contract with option to renew. The Offices anticipate that the Phase I BHO will be operational for up to two years.

80. Section IV: Administrative and Legal Information Section I. Reserved Rights – How could The Offices make an award in part? Section J. Contract-Form and Term – It says that the anticipated length of the project is 2 years. But, other sections say 3 years. Please clarify.

Answer: The contract will be a one year contract with option to renew. The Offices anticipate that the Phase I BHO will be operational for up to two years.

81. How large of a program is MATS?

Answer: There are 870 total active participants; 718 in NYC and 152 in upstate counties.

82. Will they be providing start up money to the awarded bidder? If so for how many months during the inception?

Answer: There will not be funding of the costs involved in preparing the entity to become ready to provide services. Payment will be made for services provided during the time between commencement of operation and the time when the contractor becomes fully operational. That time period may not exceed three months.

Pharmacy

83. To what extent will the selected BHOs see behavioral pharmacy data, by what frequency and format?

Answer: Pharmacy data will be provided to the BHO along with all other Medicaid claims and encounters. The format will be determined after the bids are awarded.

84. When will behavioral health pharmacy be managed under the MCOs?

Answer: The [workplan for the Medicaid Redesign Team \(MRT\)](#) [☞] can be found on the DOH website. Pharmacy is covered by MRT #11.

85. (#59) When will behavioral health pharmacy for the ABD population specifically be managed by the MCOs? What is the timeframe we are looking at here, or will it ever be managed by BHO's in a combined plan?

Answer: The [workplan for the Medicaid Redesign Team \(MRT\)](#) [☞] can be found on the DOH website. Pharmacy for ABD is covered by MRT #11. Phase I of the BHO will not manage pharmacy.

86. Medication reconciliation can be essential to reducing readmission rates. Can the State discuss how the Pharmacy benefit will be administered (e.g., with the TANF population be carved into the MCO system) and how Pharmacy costs will be reimbursed?

Answer: Pharmacy will be reimbursed by the Medicaid Managed care plans for all Medicaid Managed Care enrollees, including enrollees whose coverage excludes all psychiatric inpatient, mental health clinic and specialty practitioner services. Pharmacy claims data will be made available to the BHO.

87. What pharmacy data will be made available to the BHO for profiling purposes?

Answer: Pharmacy claims data will be made available to the BHO.

88. What prescription drug data on individuals in mainstream managed care will be available to BHO? How frequent and with how long a lag will there be?

Answer: Pharmacy claims data will be made available to the BHO. Although the pharmacy benefit for most individuals whose admissions will be reviewed by the BHOs will now be managed by the Medicaid managed care plans, DOH and The Offices expect the information to be available to the BHOs at least as quickly as it is available currently, when it is managed/paid directly by eMedNY. DOH intends to require submission of pharmacy encounters on a weekly basis with weekly data pushes to the Medicaid Data Warehouse in order to preserve rapid availability of pharmacy data.

Regional Cost Parameters

89. p. 27, 4. Budget, d. Regional Cost Parameters. Will any health systems be exempt from BHO reviews? For example, in the New York City region will HHC or Montefiore medical system be exempt from reviews?

Answer: No health systems are exempt from BHO reviews.

90. Please confirm that the Regional Cost Parameters laid out on Page 27 of the Selection Process Document Instructions apply to a one-year period of time.

Answer: The cost parameters apply to a one year time frame.

91. Page 27 - Are the Regional Cost Parameters an anticipated annual budget? Page 7 (Form and Term) states that the anticipated length of the project is two years and that the term of any contract(s) awarded shall be for one year. Budget appendices cover 2 years. Please clarify if the Regional Cost Parameters are for 12 or 24 months.

Answer: The cost parameters apply to a one year time frame.

Regions

92. Will there be 1 BHO selected for each region? Is it possible there will be 2 in NYC?

Answer: It is the intent of OMH and OASAS to award contracts in up to five regions corresponding with the map on page 12 of the solicitation. Applicants' responses should anticipate one contract per region.

93. RFP Section IX, BHO Regions, page 12 and Section XVII.4 Budget, Operating Budget Form, page 26. Page 12 indicates that applicants may choose to bid on more than one region and, if so, to rank the regions. The Budget Forms do not allow a price for differing regions, Should applicants submit a unique comprehensive proposal for each region for which the applicant bids, or should applicants submit a single narrative description with specifics for each region within each appropriate section and five budget forms?

Answer: Applicants need to submit a full response for each region they are bidding on.

94. Did you state that a full RFP Response will be needed for each region? Or did this refer specifically to budget sheets?

Answer: Applicants need to submit a full response for each region they are bidding on.

95. Page 12 – Applicants are asked to rank the regions in their order of preference. On page 26, #4 asks for the Operating Budget Form and Budget Narrative. Is the bidder required to complete a Budget Form and Budget Narrative for each region for which they would like to be considered?

Answer: Applicants need to submit a full response for each region they are bidding on.

96. p. 12, IX. BHO Regions. If Bidders will be using a different subcontractor for different regions, should separate applications be submitted?

Answer: Applicants need to submit a full response for each region they are bidding on.

Staff

97. Selection Process Document Instructions – XII. Staffing Requirements – Page 19 – If The Offices awarded more than on contract/region to a bidder, will each region require a separate project director?

Answer: Yes, separate project directors are required for each region.

Subcontracting

98. What are the requirements for vendors as regards to hiring of women & minority subcontractors & related?

Answer: Contractors will be bound by the provisions of Article 15-A of the Executive Law and its regulations. The purpose of Article 15-A is to promote the opportunity for equal participation in our economic system of minority and women owned business enterprises (MWBE) in regard to State contracts and procurement activities and to ensure that minority group members and women are afforded equal employment opportunities without discrimination. All bidders are encouraged to make a good faith effort to obtain active participation of certified minority and women owned business enterprises in the performance of the contract that will result from this solicitation.

99. For required Task 1, with respect to enhanced engagement activities for individuals disengaged from care, readmitted for inpatient care and who have multiple detoxification admissions, can an MCO joint venture with an organization with the capacity and expertise to deliver "high touch" care management (as contrasted with staff who call providers and clients, but never see the client) in order to most effectively address this Task?

Answer: All options will be evaluated. Required tasks must stay within the budget parameters listed on page 27 of the solicitation document. Subcontracts are not allowed without the written approval of OMH and OASAS.

100. How is subcontracting addressed re: internal affiliates?

Answer: All subcontracts, whether with an internal affiliate or others, must be approved by The Offices. Subcontractors must meet the requirements of the solicitation document to be approved. Applicants wishing to use internal affiliates to fulfill some of the requirements of this RFP are encouraged to include them in their submission. Any awards made to an applicant that has included internal affiliates and/or subcontractors that are identified in the application are deemed to approve such internal affiliates/subcontracts.

101. Selection Process Document Instructions IV Administrative and Legal Information; F. Subcontracts – Pages 5 & 15 – The RFP indicates that applicants cannot enter into subcontracts...without the written consent of The Offices. Please clarify whether this restriction also applies to structures or partnerships that utilize existing capabilities to address the required enhanced activities for the State identified subset of individuals and address readmissions and lengths of stay?

Answer: Existing structures or partnerships that contribute to the application must be included in the Organizational Information section of the bidder's application. As such they will be approved by The Offices if the applicant is the successful bidder. Any

other structure or partnership that is not described in the initial application must be approved separately by The Offices.

102. Please provide guidance re: seeking sub-contractors approval with provider organizations.

Answer: No subcontracts are allowed without the written approval of OMH and OASAS.

103. Please clarify the subcontract language relative to existing delegated partnerships previously approved by the State.

Answer: Existing delegated partnerships previously approved by the State must be submitted with and described in the application. As such the determination of approval will be provided by The Offices if the applicant is the successful bidder.

104. With respect to subcontracting for discrete services, can you explain the timeline for seeking OMH approval? For example, would an applicant identify the intended subcontractor in the proposal and seek OMH approval if selected?

Answer: Yes. If the applicant identifies the subcontractor in the application, the determination of approval will be provided as part of the award process. Any subcontractors not identified in the application will require separate written approvals by the Offices.

105. Will OMH be approving subcontractors prior to the award or post-award?

Answer: Yes. If the applicant identifies the subcontractor in the application, the determination of approval will be provided as part of the award process. Any subcontractors not identified in the application will require separate written approvals by the Offices.

106. Does subcontracting for 1 or more core services disadvantage an applicant because the arrangement is subject to OMH approval?

Answer: Not necessarily. The awards will be evaluated on the quality of the application.

Data

107. RFP Section X, Enhanced Activities for a State Identified Subset of Individuals Disengaged from Care, page 15. Is there a current criteria used and anticipated number of enrollees assigned or a percentage target to help with staffing assumptions.

Answer: [Information on how the data is calculated](#) is found on the OMH website.

The [Data tables](#) can also be found on the OMH website.

- 108. RFP Section X, Required Tasks, 10.1.2.3.1, 10.1.2.3.3, and 10.1.2.5, pages 15 and 16, The RFP states "The Offices will identify a subset of eligible adults deemed high need individuals who appear to be disengaged from needed services," The BHO is required to assist the hospital in discharge planning for these individuals. Similarly, enhanced activities will need to be performed by the BHO for individuals readmitted for inpatient care and for individuals who have had multiple admissions for detox services. To help determine staffing, do the Offices have an estimate of the number of eligible adults who will fall into these three categories?**

Answer: [Information on how the data is calculated](#) is found on the OMH website. The [data tables](#) can also be found on the OMH website.

- 109. Have reporting requirements, including reporting formats, reporting periods, and data transmittals been defined? When will they be available for review?**

Answer: Specifics of report formats, specification of reporting periods and data transmittal will be determined post award.

- 110. What is the Medicaid population by region and how much growth in this population is anticipated over the term of the contract?**

Answer: [Published data on the Medicaid population](#) [↗] can be found on the OMH website.

- 111. How many OMH licensed clinics designated as Specialty Clinics are there in each region?**

Answer:

Region	Number of Specialty Clinics
Central NY	10
Hudson River	19
Long Island	9
New York City	70
Western NY	24
Total	129

112. How many children in MMC were served in those clinics in 2010?

Answer: The number of MMC recipients who were diagnosed with Serious Emotional Disturbance in 2010 is provided below.

Region	Number of Children
Central NY	1634
Hudson River	3032
Long Island	351
New York City	17662
Western NY	4997
Total	27618

113. Will the BHO have access to PSYCKES?

Answer: Yes, pursuant to the terms of a Qualified Service Organization /Business Associate Agreement which complies with the requirements of applicable State and Federal confidentiality laws, including 42 CFR Part 2 and HIPAA, the BHO will have access to PSYCKES.

114. Section V: New York’s Mental Health System – Office of Mental Health – Of the 600,000 people served by OMH licensed programs, how many are in Managed Medicaid plans and how many have Medicaid FFS?

Answer: [Data on the Medicaid population](#) can be found on the Department of Health website.

115. Many triggers seem to be related to claims data. What is the current filing limit on claims submission to Medicaid FFS?

Answer: Generally, providers must submit fee-for-service claims to eMedNY within 90 days of the date of service. Providers may request exemption from this limit for cause.

116. Will OMH share the criteria used to identify the subset of eligible adults deemed high need individuals who appear to be disengaged?

Answer: This [data book information](#) can be found on the OMH website.

117. Regarding 10.1.2.4.3, what is the average claims lag? How will the State monitor timeliness of engagement of services if there is a lengthy claims lag?

Answer: The State is aware that sufficient time for claims run out will need to be factored in when computing performance measures. Prior OMH analysis has shown that approximately three-quarters of inpatient and outpatient claims have been paid within 60 days of the date of service.

118. Will the State be monitoring or reviewing ER utilization?

Answer: This data will be monitored using Medicaid claims data.

Data Sharing - OMH to BHO

119. Please describe the options that would be available for successful BHO bidders to access Medicaid claims data.

Answer: Pursuant to the terms of a Qualified Service Organization /Business Associate Agreement which complies with the requirements of applicable State and Federal confidentiality laws, including 42 CFR Part 2 and HIPAA, The Offices will share Medicaid claims data and reports with the BHO. Full specification of the data elements and means of transmittal will be determined during the implementation process post selection. The State also intends to make PSYCKES available to BHOs.

120. Will the claims information be transmitted in a file that the BHO downloads into their computer system or will we be able to get the data through a portal or through the OMH website?

Answer: Full specification of the data elements and means of transmittal will be determined during the implementation process post selection.

121. When will bidders have access to utilization data and statistics?

- a. Medical Claims**
- b. Behavioral Health (Mental Health & Chemical Dependency) Claims**
- c. Pharmacy Claims**
- d. Eligibility**

Answer: This data will be made available after award of the contract and pursuant to the terms of a Qualified Service Organization/Business Associate Agreement which complies with the requirements of applicable State and Federal confidentiality laws, including 42 CFR Part 2 and HIPAA.

122. Can bidders submit a proposal for a combined region in terms of strategic pricing?

Answer: Separate bids are required but supplemental information related to pricing options will be accepted in the budget sheets.

123. What information will the State provide to assist in coordination of physical and mental health between the BHO and managed care plans?

Answer: The BHO will be provided with access to comprehensive Medicaid claims and encounter data pursuant to the terms of a Qualified Service Organization/Business Associate Agreement which complies with the requirements of applicable State and Federal confidentiality laws, including 42 CFR Part 2 and HIPAA.

124. How will data be received by Contractors from the State relative to enrollment?

Answer: Individuals are not enrolled in the BHO. Full specification of the data elements and means of transmittal will be determined during the implementation process post selection.

125. p. 14, Section X. BHO Scope of Work, 10.1.1.3. How frequently will the Medicaid claims be provided to the Contractor?

Answer: The State intends to make PSYCKES available to the BHOS. The Medicaid data viewable through PSYCKES is refreshed on a weekly basis. Details regarding transmittal of claims files will be determined post award, but it is the State's intent create a process that permits weekly data feeds.

126. p. 14, Section X. BHO Scope of Work, 10.1.2. Will the 'high risk' individuals be identified via Eligibility or the Medicaid Claims data? How frequently will the data be provided to the Contractor?

Answer: The high need/disengaged cohort referenced in the RFP will be identified by OMH from claims data and other sources. The listing of such individuals will be refreshed on a monthly basis.

127. For many reports, it is important to determine both what information and for whom Medicaid data will be available. Will we receive both the admission claims and subsequent outpatient claims for all Medicaid individuals admitted to facilities?

Answer: Yes. It is the intent of the Offices to make inpatient, outpatient and pharmacy data available.

128. RFP Section B.10.1.1 – Please confirm this report will be generated using claims data. (OMH sought and received the following clarification on the question):

XIV.B.1 (Task 10.1) on page 22-23 – Report on a monthly basis the number of times the BHO provided inpatient staff with information on the patient's service history relevant to treatment and discharge planning (e.g., previous medications, providers, apparent medical co-morbidities) within 48-72 hours of the client's admission.

Please confirm the patient's service history will be generated using claims data.

Answer: The patient's service history will be available on PSYCKES, which is generated primarily from claims history, or from claims and Medicaid Managed Care encounter history. This information has to be supplemented with information regarding recent inpatient admissions, readmissions and discharges, from the most recent 60-90 days, which will have been directly reported by inpatient providers to the BHO and will

not have necessarily produced a Medicaid paid claim or Medicaid Managed Care encounter available to DOH.

129. Can the state share a FFS file layout for claims data transfer?

Answer: Full specification of the data elements and means of transmittal will be determined during the implementation process post selection.

130. Selection Process Document Instructions – 10.1.2.3.1 – Page 15 – When will the BHO receive the first list of individuals eligible for enhanced activities from the Offices and what information will be included in this list?

Answer: It is the intent to have the first monthly listing available at the start of implementation. The file will include identifying information on the individual, at a minimum name, date of birth and Medicaid ID number.

Data Sharing - BHO to OMH

131. RFP Section X, Required Tasks, 10.2, Children's Outpatient SED Tracking, Requirement 10.2.2, page 17. Will the Interim Specialty Clinics provide the BHO with all the required data elements, including functional limitations, to be submitted in the report to OMH or will the BHO be required to obtain some of the information from other sources? Is there an established form or other reporting mechanism currently in use to collect this data?

Answer: OMH will require outpatient clinics to report this information to the BHO. In the case of SED children, the applicant will propose a solution to accomplish the collection and tracking of this information.

132. p. 17, 10.3 Task 3: Provider profiling, 10.3.2. Additional Reports Prepared by the BHO. Please provide a sample layout of an “electronic manner acceptable to and accessible by The Offices.”

Answer: These will be developed in consultation with the selected applicant.

133. p. 22, A. Reporting Deliverables, #2. Separate Data File. What is the anticipated lag time on the data file from the Specialty Clinics for children with SED?

Answer: Data will be reported by the clinics directly to the BHO. The BHO will provide this data to the State on a quarterly basis.

134. Selection Process Document Instructions A. Reporting Deliverables (#2 on page 22) – Page 22 – Per #2 on page 22: “A Separate data file will be provided monthly based on the information collected from OMH licensed clinic programs with the Specialty Clinic Designation.” Please clarify that the BHO is responsible for collecting this specified data?

Answer: Yes, the BHO must collect this data from the Specialty Clinics.

Metrics

135. What contractor "performance standards" have been established and when will they be available for viewing?

- a. Will there be an audit process?
- b. Who will conduct the audits?

Answer: Applicant should review the selection process document for a list of performance metrics. All metrics are subject to audit by the Offices.

136. Attachment F: How and when will the targets for each metric be determined?

Answer: Targets will be established using existing Medicaid claims data to determine present system performance on these metrics.

137. Given the advisory nature of concurrent review determinations and the formative nature of the BHO, please confirm that the metrics in Attachment F are not associated with monetary incentives or penalties.

Answer: Correct, metrics in Attachment F are not associated with monetary incentives or penalties.

Recipient Eligibility Criteria

138. Can you tell me whether or not there are a minimum/maximum set number of covered lives that a BHO would need to manage to be designated as a regional BHO? (Ex. 5,000, 10,000 etc)

Answer: In Phase I, the BHO does not have covered lives. Rather it monitors inpatient and discharge planning for individuals whose behavioral health inpatient stays are reimbursed by Medicaid on a fee for service basis in the following venues:

- Admissions to OMH-licensed psychiatric units (all ages) in general hospitals (Article 28 hospitals);
- Children and youth admitted to OMH licensed psychiatric hospitals (Article 31 hospitals);
- Children and youth direct admissions (i.e., not transfers) to OMH State operated children's psychiatric centers or children's units of psychiatric centers;
- OASAS certified hospital (Art 28/32) or freestanding (Article 32 only) Part 818 Chemical Dependence Inpatient Rehabilitation Services; and
- OASAS Certified Part 816 Inpatient Detoxification Services (Article 28/32). [Data on the use of these services](#) has been provided and can be found on the OMH website.

139. Page 10 (VII) - Describes eligible individuals who will be eligible for the BHO. Will OASAS/OMH provide the successful BHO with an eligibility file of Medicaid enrollees?

Answer: In Phase I, the BHO does not have covered lives. Rather it monitors inpatient and discharge planning for individuals whose behavioral health inpatient stays are reimbursed by Medicaid on a fee for service basis in the following venues:

- Admissions to OMH-licensed psychiatric units (all ages) in general hospitals (Article 28 hospitals);
- Children and youth admitted to OMH licensed psychiatric hospitals (Article 31 hospitals);
- Children and youth direct admissions (i.e., not transfers) to OMH State operated children's psychiatric centers or children's units of psychiatric centers;
- OASAS certified hospital (Art 28/32) or freestanding (Article 32 only) Part 818 Chemical Dependence Inpatient Rehabilitation Services; and
- OASAS Certified Part 816 Inpatient Detoxification Services (Article 28/32). [Data on the use of these services](#) has been provided and can be found on the OMH website.

140. In several areas of the document, there is reference to SED children and SPMI adults being managed currently in fee for service. The RFP appears to indicate these individuals would be managed by the successful bidder and remain in FFS. However, a recent letter from Vallencia Lloyd from DOH to the state's Medicaid managed care plans included an attachment summarizing the population expansion to Medicaid managed care planned as a result of the MRT process (attached for your reference). This document indicates that non-SSI SPMI adults and non-SSI SED children will begin to be enrolled into managed care beginning 10/1/11 -- the same date as the regional BHO would take effect. Could you please clarify whether these populations would be in FFS or in plans on or after October 1, 2011?

Answer: In Phase I, the BHO does not have covered lives. Rather it monitors inpatient and discharge planning for individuals whose behavioral health inpatient stays are reimbursed by Medicaid on a fee for service basis in the following venues:

- Admissions to OMH-licensed psychiatric units (all ages) in general hospitals (Article 28 hospitals);
- Children and youth admitted to OMH licensed psychiatric hospitals (Article 31 hospitals);
- Children and youth direct admissions (i.e., not transfers) to OMH State operated children's psychiatric centers or children's units of psychiatric centers;
- OASAS certified hospital (Art 28/32) or freestanding (Article 32 only) Part 818 Chemical Dependence Inpatient Rehabilitation Services; and
- OASAS Certified Part 816 Inpatient Detoxification Services (Article 28/32).

Additionally, the letter cited from the Health Department does not relate to mental health services. It addresses population expansion related to particular benefits including:

- Personal Care services
- Pharmacy in benefit package
- Personal Emergency Response System (PERS)
- Consumer Directed Personal Assistance Program (CDPAP)
- Skilled Nursing Facility Services

141. From your response the expansion of M/A coverage to people with SMI and SED, does that mean by virtue of “Dx” people cannot be enrolled in Managed Care?

Answer: It is the intent of New York to enroll all Medicaid recipients in some form of managed care in the next three years. Some Medicaid Managed Care Plans do not “cover” psychiatric inpatient care. The Medicaid fee-for-service admissions to the various behavioral health venues described in the procurement include these individuals enrolled in so-called ‘health only’ Medicaid Managed Care and those individuals who are not enrolled in Medicaid Managed Care. As the percentage of Medicaid enrollees enrolled in Medicaid Managed Care increases, the number of individuals enrolled in ‘health only’ plans will change, as will the number of enrollees remaining outside of Medicaid Managed Care.

Reporting Requirements

142. BHO must use report format approved by The Offices when providing "Reporting Deliverables" (page 21). Will these formats be approved post-award?

Answer: Yes, these reports will be approved post award.

Stakeholders: Communication and Cooperation

143. Could you please specify who at a minimum the Offices consider as being a "stakeholder" for this proposal?

Answer: Stakeholders include but are not limited to Local Governmental Units (LGU) (see Article 41 of the New York State Mental Hygiene Law), physical and mental health providers, insurers, consumer groups, family groups, health homes and other appropriate organizations in the BHO’s region.

144. How will in- and outpatient providers notify the BHO of the information detailed in the RFP, such as SED diagnoses of children? Does OMH envision a secure online capability? Or will each applicant propose a solution to accomplish the task?

Answer: OMH and OASAS (as appropriate) will require inpatient and outpatient clinics to report this information to the BHO. In the case of SED children, the applicant will propose a solution to accomplish the collection and tracking of this information.

145. p. 17, 10.3 Task 3: Provider profiling, 10.3.4., Local Governmental Units (LGU). Please provide more specifics about how The Offices would like the regional BHOs to interface with the Local Governmental Units.

Answer: The procurement requires contact and consultation with the LGU. The Offices are asking the bidder to identify the frequency and mode of this interface.

146. Are The Offices contemplating any incentives for hospitals and providers to cooperate with the BHO?

Answer: No. The Offices will issue regulations and/or Local Services Bulletins requiring providers to contact the regional BHO.

147. How does BHO and Health homes work together or separately to engage and facilitate care to high cost / high need individuals? Can you describe their distinct roles or do their roles overlap?

Answer: The relationship between the BHO and the Health Homes will be worked out as health homes roll out in different parts of the State. At a minimum, the BHO will:

- Share information on provider patterns of care with health homes in the region.
- The BHO will encourage inpatient providers to develop linkages with health homes.
- Proactively develop relationships with health homes.

148. Please describe the role of local districts in selection process.

Answer: Only proposals submitted for the NYC region will have a reviewer from the local government unit involved in the selection process.

149. Please discuss in detail the expectations of BHO in the way it will work with mainstream managed care plans to coordinate care for those individuals enrolled in mainstream managed care whose behavioral health benefits are carved out. What requirements, if any, would be imposed on mainstream managed care plans to facilitate communication/coordination?

Answer: In general, the BHO will coordinate with Medicaid managed care companies to facilitate access to care and coordinate care for high needs high cost individuals with concurrent physical health needs that are in or have been discharged from behavioral health inpatient settings.

150. Section III: Purpose and Goals. Can the BHO share information with providers about a consumer's past Medicaid service use without member consent?

Answer: In non-emergency situations a BHO may communicate with the treating mental health inpatient provider regarding a client's mental health information without consent. In situations where the BHO possesses additional information that requires consent, such as substance abuse or HIV information, a BHO may advise the treating mental health provider that additional health history information is available and will be provided once the provider obtains the client's consent to disclose the additional health history information.

In non-emergency situations a BHO may only communicate with the treating SUD provider regarding health history information when the client has consented to such communication.

Where the treating mental health or SUD provider determines an emergency condition exists, communication between the treating provider and BHO may occur without consent. Communication between a BHO and provider(s) can also occur in situations where such communication is authorized by a Court Order.

Definition of medical emergencies under 42 CFR Part 2:

§ 2.51 Medical emergencies.

- a) General Rule. Under the procedures required by paragraph (c) of this section, patient identifying information may be disclosed to medical personnel who have a need for information about a patient for the purpose of treating a condition which poses an immediate threat to the health of any individual and which requires immediate medical intervention.
- b) Special Rule. Patient identifying information may be disclosed to medical personnel of the Food and Drug Administration (FDA) who assert a reason to believe that the health of any individual may be threatened by an error in the manufacture, labeling, or sale of a product under FDA jurisdiction, and that the information will be used for the exclusive purpose of notifying patients or their physicians of potential dangers.
- c) Procedures. Immediately following disclosure, the program shall document the disclosure in the patient's records, setting forth in writing:
 - 1) The name of the medical personnel to whom disclosure was made and their affiliation with any health care facility;
 - 2) The name of the individual making the disclosure;
 - 3) The date and time of the disclosure; and
 - 4) The nature of the emergency (or error, if the report was to FDA).

151. Will the BHO need to have a business associate agreement with each provider to share past Medicaid service information?

Answer: The BHO will not have to have a business associate agreement with the provider.

152. Do the BHO's need to have confidentiality/data exchange agreements with all the Managed Medicaid plans?

Answer: No. The Managed Care plans are not, in fact, sharing the encounter information with the BHOs. The DOH receives this information from the Managed Care

plans and will be providing this information directly or indirectly to the BHOs pursuant to agreements between the BHOs, DOH, OASAS and OMH.

153. Do inpatient providers have access to the PSYCKES database? Wouldn't this give them information about a consumer's past Medicaid service use?

Answer: Some but not all hospital providers have access to PSYCKES. The hospitals' access to and use of PSYCKES information does have certain limits in the absence of patients' consent.

154. Will the BHO be expected to share information about the member's past treatment for medical conditions? If so, how will the BHO have access to this type of information? Can we share this information with the provider even if the member is enrolled in a Managed Medicaid plan?

Answer: PSYCKES and the raw claims information provided/available to the BHO will include information about all services paid by Medicaid on a fee-for-service basis and services reimbursed by Medicaid Managed Care plans, with the information regarding those services submitted by the plans to DOH (i.e., encounter information). This information can be shared pursuant to the same confidentiality guidelines outlined in responses to questions 150-152, above.

155. Facilitate cross-system linkage. Regarding 10.4.4, it says the BHO will facilitate linkage to physical health (subject to approval by OMH, OASAS and DOH). What would OMH, OASAS and DOH need to approve?

Answer: The Offices will review and approve the BHO's approach to collaboration and coordination of care with Medicaid Managed Care Plans.

156. How will the state "require" providers to contact their regional RBHO?

Answer: The Offices will issue regulations and/or Local Services Bulletins requiring providers to contact the regional BHO.

157. Selection Process Document Instructions – 10.1.1.2 – Page 13 – What steps will The Offices take to require that hospitals notify the BHO within 24 hours of admission?

Answer: The Offices will issue regulations and/or Local Services Bulletins requiring providers to contact the regional BHO.

158. Attachments such as the audited financial statements are not available in Word. They are in PDF format only. Is it acceptable to submit them on the USB in PDF format only?

Answer: Yes.