

**Behavioral Health Organizations
Selection Process Document Instructions**

June 24, 2011

New York State
Office of Mental Health

New York State
Office of Alcoholism and
Substance Abuse Services

Contents

I.	Introduction	3
II.	Authority	3
III.	Purpose and Goals of this Selection Process Document	3
IV.	Administrative and Legal Information.....	4
V.	New York's Mental Health System.....	8
VI.	New York's Substance Use Disorder System	9
VII.	Current Medicaid Population and Benefit Structure	10
VIII.	Services Reviewed by the BHO.....	11
IX.	BHO Regions	12
X.	BHO Scope of Work	13
XI.	Additional Capabilities	18
XII.	Staffing Requirements	19
XIII.	BHO Quality Assurance Program	20
XIV.	Deliverables.....	20
XV.	Behavioral Health Systems Evaluation	24
XVI.	Timeframe for Implementation.....	24
XVII.	BHO Development and Submission Instructions	24
XVIII.	Review and Selection Criteria.....	32
	Attachment A: Data Book	33
	Attachment B: BHO Statute – Chapter 59 of the laws of 2011, Part H Section 42.d.....	34
	Attachment C: Schedule of MMC and FFS Benefits – With Major Changes Proposed under Medicaid Redesign Team (MRT) Initiatives	36
	Attachment D: Monthly Reporting Data for Hospital Admissions and Discharges	42
	Attachment E: Reporting and Task Deliverables.....	44
	Attachment F: Mental Health System Metrics	48
	Appendix A: Agency Transmittal Form	50
	Appendix B: Operating Budget Form	50
	Appendix B-1: Budget Narrative.....	50

I. Introduction

The New York State Office of Mental Health (OMH), in conjunction with the New York State Office of Alcoholism and Substance Abuse Services (OASAS), hereinafter referred to as “The Offices” is accepting applications for regional behavioral health organizations to provide administrative and management services for the purposes of conducting concurrent review of inpatient behavioral health services and coordinating the provision of behavioral health services and other services available under the medical assistance program.

II. Authority

A key element of the New York State Medicaid agenda is to increase the quality and efficiency of the Medicaid program and reduce Medicaid costs. To accomplish these objectives, Governor Cuomo created a Medicaid Redesign Team (MRT). The MRT consists of representatives from the Legislature, health care industry, patient advocacy groups, and State executive staff including the Commissioners of the Office of Mental Health and the Office of Alcoholism and Substance Abuse Services, and the New York State Medicaid Director. Many recommendations from the MRT were adopted into New York State law.

One of the enacted recommendations ([Chapter 59 of the Laws of 2011, Part H, Section 42-d](#)) gives the Commissioners of the Office of Mental Health and the Office of Alcoholism and Substance Abuse Services the authority to jointly select and contract for the services of one or more regional behavioral health organizations. These entities will assist in the management of behavioral health services for individuals not enrolled in managed care for the receipt of their behavioral health services, and for those services that are “carved out”, i.e. not covered, by a Medicaid Managed Care (MMC) plan, regardless of whether the recipient is enrolled in a managed care plan that includes behavioral health services or not.

Implementation of the BHO is divided into two phases. Phase I is shown in the [Scope of Work](#) of this document. Phase II requirements are still to be developed and will be the subject of a later selection process. A goal over the next three years is to have every Medicaid recipient enrolled in some form of care management for his or her health and behavioral health benefits.

III. Purpose and Goals of this Selection Process Document

The purpose of this selection process is to select BHO’s to achieve the goals of Phase I including:

- Monitoring behavioral health inpatient length of stay;
- Reducing unnecessary behavioral health inpatient hospital days;
- Reducing behavioral health inpatient readmission rates;
- Improving rates of engagement in outpatient treatment post discharge;

- Better understanding of the clinical conditions of children diagnosed as having a Serious Emotional Disturbance (SED);
- Profiling provider performance; and
- Testing metrics of system performance;

To accomplish these goals the BHO will interact with the inpatient provider around each fee-for service (FFS) admission. The BHO will be able to provide information to the inpatient provider regarding past Medicaid paid service use to assist in treatment and discharge planning. The BHO will conduct concurrent reviews against continued stay criteria and will review the discharge plan for completeness and appropriateness.

IV. Administrative and Legal Information

A. Designated Contact

The Offices have assigned a designated contact agent for this selection process. The designated contact or her designee shall be the sole point of contact regarding the selection process from the date of issuance of the selection process document until the issuance of a notice of conditional award. Applicants are restricted from making contact with any other personnel of The Offices related to this selection process document during this time period.

The designated contact for this selection process document is:

[Susan Penn](#)
Contract Management Specialist 2
Office of Mental Health
44 Holland Avenue
7th Floor
Albany, NY 12229
Fax number: (518) 402-2529

B. Bidder's Conference

An informational Bidder's Conference will be held on Thursday, **July 7** from 1:00 p.m. until 5:00 p.m. in Albany New York. See [OMH Web News](#) or [OASAS Procurements](#) for more information as it becomes available. Attendance is limited to four representatives for each Applicant. Attendance is not mandatory.

To confirm your attendance, please contact [Gwen Diamond](#) at (518) 474-6911 by July 6, 2011.

C. Questions Related to This Selection Process

Please submit questions via email, letter and/or fax by **5:00 pm on July 7, 2011** to **Susan Penn, the designated contact (contact information listed above)**. Along with your question(s), please provide your name, organization, mailing address, email address, and fax number. Please reference the **OASAS/OMH 2011 BHO Selection Process Document** in your submission. The Offices will not entertain questions via telephone, questions not submitted to the addresses indicated above, or questions received after the deadline date listed above. Questions will not be answered on an individual basis. Written responses to inquiries submitted and all questions asked at the Bidders' Conference will be posted on the OASAS and OMH websites on or about July 15th, 2011.

D. Changes and Notification

In the event it becomes necessary to revise any part of this Selection Process document prior to the scheduled submission date for proposals, an addendum will be posted on the OMH and OASAS websites. It is the proposing organization's responsibility to periodically review the OMH and OASAS websites to learn of revisions or addendums, as well as to view the official questions and answers. No other notification will be given.

E. Key Events Timeline:

Key Events	Date
RFP Release	June 24, 2011
Deadline for Submission of Questions	July 7, 2011
Bidder's Conference	July 7, 2011
Questions and Answers Posted on OMH/OASAS Website	*July 15, 2011
Proposals Due	August 5, 2011
Notice of Conditional Award	*August 19, 2011
Contract Start Date	*October 1, 2011

*These are estimated dates

F. Subcontracts

The Successful Applicant(s) agree not to enter into any subcontracts for the performance of contractual obligations without the express written consent of The Offices.

G. Proposal Security and Public Information

The content of each Applicant's proposal will be held in strict confidence during the evaluation process, and details of any proposals will not be discussed outside the evaluation process.

Disclosure of information related to this Selection Process and the resulting contract shall be permitted consistent with the laws of the State of New York including the Freedom of Information Law (FOIL) contained in Article 6 of the Public Officers Law. If an Applicant submitting a proposal feels that public disclosure of such proposal or portions thereof would result in substantial injury to the competitive position of the Applicant's firm, it may request that the proposal or portions thereof be kept separate and apart from other agency records on the grounds that the proposal contents constitute trade secrets or critical infrastructure information for purposes of FOIL. Such a request must be submitted in writing and should accompany the original submission. Determinations as to whether materials identified may be withheld from disclosure will be made in accordance with FOIL at the time such a request for information is received by The Offices.

H. Rights to Materials Produced

All products and written materials developed pursuant to a contract issued as a result of this Selection Process shall be and remain the sole property of The Offices, which shall have the exclusive right of copyright thereto. The successful applicant(s) must secure written permission from The Offices to use any such materials for purposes other than those specified in the *Scope of Work*.

The Offices shall have the sole exclusive right to publish, duplicate, use and disclose all such data in any manner and, for any purpose whatsoever, and may authorize others to do so.

I. Reserved Rights

The Offices reserve the right to:

- Reject any or all proposals received in response to this selection process;
- Withdraw the selection process document at any time, at their sole discretion;
- Make an award under this selection process in whole or in part;
- Make awards based on geographical or regional consideration to best serve the interests of the State;
- Disqualify any Applicant whose conduct and/or proposal fails to conform to the requirements of this selection process;
- Seek clarifications and revisions of proposals;

- Use proposal information obtained through site visits, management interviews and The Office's investigation of a Applicant's qualifications, experience, ability or financial standing, and any material or information submitted by the Applicant in response to The Offices' request for clarifying information in the course of evaluation and/or selection under the selection process;
- Prior to the bid opening, amend the selection process document to correct errors of oversights, or to supply additional information as it becomes available;
- Prior to the bid opening, direct Applicants to submit proposal modifications addressing subsequent selection process document amendments;
- Modify any of the scheduled dates;
- Eliminate any mandatory, non-material specification that cannot be met by all of the prospective Applicants;
- Waive any requirement that is not material;
- Negotiate with the successful Applicant within the scope of the selection process in the best interests of the State;
- Conduct contract negotiations with the next responsible Applicant, should The Offices be unsuccessful in negotiating with the selected Applicant;
- Require correction of simple arithmetic or other apparent errors for the purpose of assuring a full and complete understanding of an Applicant's proposal and/or to determine a Applicant's compliance with the requirements of the solicitation;
- Cancel or modify contracts due to the insufficiency of appropriations;
- Cancel or modify contracts due to cause within 30 days; and
- Cancel or modify contracts without cause within 60 days.

J. Contract – Form and Term

If an award(s) is made pursuant to this selection process, a contract containing terms and conditions will be negotiated with the Successful Applicant(s) based on this selection process document and the successful proposal. The Contract will include, but not be limited to standard clauses for all New York State contracts, the selection process document, the proposal received and appendices, exhibits and any other attachments.

The anticipated length of the project is two years. The term of any contract(s) awarded shall be for one year with the option to renew for up to four more years, subject to available funding.

V. New York's Mental Health System

Behavioral health services in New York are licensed, funded and overseen by The Offices. What follows is a brief overview of these systems and links to additional data.

Office of Mental Health

OMH funds and licenses more than 2,500 mental health programs serving 600,000 people annually. These programs are operated by the State, local governments, not-for profit agencies and for profit organizations. They provide outpatient, inpatient treatment, rehabilitation, emergency services, housing, community support and/or vocational services. The majority of program recipients are either individuals with a serious mental illness (SMI) or children and adolescents who have a serious emotional disturbance (SED). These individuals suffer from the most difficult and complex mental health conditions and often have co-morbid physical health and substance use ailments.

Funding for the system's array of services is complex, including Medicaid, State aid, county support, other funding, and private insurance. The Medicaid program is the State's largest payer for mental health services, and accounts for 48% of the \$7.1 billion public mental health system. Inpatient psychiatric services in discrete psychiatric units of general hospitals, private psychiatric hospitals and OMH-operated psychiatric centers represent \$3.67 billion of total mental health spending.

The financing of children's mental health is also complex and in need of realignment. For children, Medicaid is not a proxy for serious emotional disturbance. Overall, approximately 60% of children served have Medicaid. The remaining 40% are either commercially insured or do not have insurance. There is also significant geographic variance in the payer mix for public mental health services for children.

Current safeguards to ensure access to specialty treatment for children with SED through the use of Medicaid Managed Care carve-outs are confusing for providers and have not promoted collaborative care.

1. Adult Mental Health Services

For many adults with serious mental illness, this broad array of treatment options is difficult to navigate, and has led to fragmentation of service delivery. The current service system does not always ensure priority access to individuals with the highest needs, services provided by different clinicians are not always well-coordinated, and payments for services provided are not always structured to provide incentives that promote recovery.

In 2008, NY City and State government leaders, faced with a number of tragic events linked to fragmentation of care, convened a Panel to examine and recommend actions to improve the public safety while enhancing the care of high need individuals with serious mental illness. The Panel found that the

system in place to coordinate care across agencies or to engage people who have dropped out or been lost to care is ineffective. The Panel recommended creating “care monitoring” teams to improve accountability and reduce service failures. These teams would use Medicaid claims and other State administrative data to identify high-need individuals with SMI at risk for lapses in care, overuse of inpatient and emergency services, and poor outcomes while monitoring these individuals and their caregivers. Teams were piloted in Brooklyn and expanded to the Bronx and then city-wide. The creation of BHOs represents the next step in moving the statewide system toward recovery- focused accountability and reducing system fragmentation.

2. Children’s Mental Health Services

Emotional disturbances affect a staggering number of children. More children suffer from psychiatric illness than from autism, leukemia, diabetes, and AIDS combined. One out of ten children has a serious emotional disturbance. The reach of the Children’s mental health system is broad, ranging from social emotional development, through early identification of mild to moderate emotional disturbances, to a complex array of specialty treatment, skill-building and support services for children with serious emotional disturbances.

3. Additional Information

As a result of history, population, funding, and local priorities, the structure and content of mental health services vary considerably by region and county. For a more complete overview of the New York Mental Health System, see:

1. [2009 OMH Ambulatory Restructuring Project Report](#)
2. [OMH Planning Website](#)
3. [OMH Statistics and Reports](#)
4. [Attachment A: Data book](#)

VI. New York’s Substance Use Disorder System

OASAS plans, develops and regulates the State’s system of substance use disorder and gambling treatment agencies. This includes the direct operation of 12 Addiction Treatment Centers, which provide inpatient rehabilitation services to approximately 10,000 persons per year. In addition, the Office licenses, funds, and supervises some 1,300 community-based substance use disorder treatment programs, which serve about 110,000 persons on any given day in a wide range of comprehensive services. The agency inspects and monitors these programs to guarantee quality of care and to ensure compliance with State and national standards.

OASAS certifies 10 Residential Rehabilitation Services for Youth (RRSY) that Medicaid reimburses on a fee-for-service basis for all children, including those

enrolled in Medicaid Managed Care. These programs served 2,026 children in 2010 and provide comprehensive substance use disorder treatment that addresses physical, mental health, educational and other social needs. OASAS has a commitment to meeting the unique needs of children and their families utilizing evidence-based treatments. The current process for accessing these residential services includes a review by the Admission Review Team (ART). OASAS expects to continue the ART review process through Phase I of the BHO and this selection process does not include any services relative to OASAS certified RRSY services.

Substance Use Disorders are chronic health conditions that often co-occur with associated mental health and physical health problems. Treatment is focused on life-long recovery and disease management skills including management of co-occurring disorders and a holistic plan for regaining health. Peer support, housing, family, social and spiritual supports are integral to successful treatment. Patients should receive care that is evidence-based including addiction and/or psychotropic medications when indicated by their history and symptoms.

For a more complete overview of the New York Substance Use Disorder System, follow the link to [OASAS Programs](#)[☞].

VII. Current Medicaid Population and Benefit Structure

There are four major categories of Medicaid enrollees for purposes of clarifying the funding structures that support the provision of behavioral health services. These include:

1. Temporary Assistance to Needy Families (TANF) and Home Relief (“Safety Net”) recipients. TANF and Home Relief/Safety Net recipients who voluntarily or mandatorily enroll in Medicaid Managed Care are assigned to Comprehensive Medicaid Managed Care plans. Behavioral health benefits include inpatient psychiatric and mental health clinic services. However, children who are identified as having a Serious Emotional Disturbance (SED) who are served by specially designated OMH licensed clinics (specialty clinics) receive clinic services on a FFS basis. Mental health services in OMH-licensed outpatient programs other than clinics, e.g. continuing day treatment (CDT), intensive partial rehabilitative treatment (IPRT), children’s day treatment (DT) and partial hospitalization (PH) are not covered by MMC for any population group;
2. Supplemental Security Income (SSI). Individuals with SSI who are assigned to “Health Only” Medicaid Managed Care plans. Currently SSI enrollees and most children in foster care in New York City do not receive any mental health services through mainstream Medicaid Managed Care plans;
3. Dual Medicaid/Medicare enrollees (Duals). These individuals are carved out of Medicaid Managed Care. Duals are excluded from this selection process for the initial term of the contract; and

4. All Other Persons NOT enrolled in Medicaid Managed Care. The Partnership Plan currently exempts a number of smaller counties from mandatorily enrolling individuals in Medicaid Managed Care. The Plan also excludes certain other individuals from enrollment in Medicaid Managed Care, including but not limited to children in foster care, homeless individuals, persons who are determined to be seriously mentally ill. Any behavioral health inpatient admission for these individuals is reimbursed by Medicaid on a fee-for-service basis.

For OASAS, MMC plans currently include Inpatient Rehabilitation services for non-SSI enrollees and Part 816 Inpatient Detoxification services for all Medicaid enrollees. However, many FFS claims are paid for Detoxification services provided to individuals who are not enrolled in MMC. Frequently these individuals are not required to enroll in MMC because of a status exemption (e.g., they are homeless). For a more detailed schedule of MMC and FFS benefits, see [Attachment C](#).

VIII. Services Reviewed by the BHO

With the exception of task 10.2, the BHO will be responsible for completing the scope of work for persons whose use of behavioral health inpatient services, as defined in [Task 10.1.1.1 in the Scope of Work](#), is paid on a Medicaid FFS basis. All tasks in the scope exclude Duals for the initial term of the contract. In subsequent years of the contract, the scope of work may be expanded to apply to Duals. At that point, reimbursement for any such additional coverage will be negotiated with BHOs already operating pursuant to this selection process.

Task 2 will apply to Medicaid recipients of services at OMH licensed outpatient clinic programs with the "Specialty Clinic" designation for children and youth.

IX. BHO Regions

Contracts will be awarded in up to five regions corresponding with the map below. Applicants may bid on more than one region but it is the intent of The Offices to select a different Applicant for each region. The Offices reserve the right to award more than one contract to a bidder if there are not sufficient high quality bids in all regions.

Applicants choosing to bid on more than one region are asked to rank the regions in order of their preference. In the event that an applicant is being considered as a contractor in more than one region, such preferences will be considered to the extent practicable, consistent with the achievement of program goals.



X. BHO Scope of Work

This scope of work is divided into four **required** tasks and additional capabilities ([Section X](#) and [Section XI](#)). All applicants must address how they would perform the required tasks as well as specify the associated cost (see [BHO development and submission instructions](#)). The additional capabilities section identifies areas for which additional information on provider capability is sought. Applicants will be required to provide a detailed response regarding their capability to perform these functions, but the anticipated cost of such services is not being sought at this time. Additional capabilities may be funded separately on a pilot basis after discussion with one or more of the selected BHOs.

REQUIRED TASKS (Note: task numbers remain constant throughout the document)

10.1 Task 1: Monitor, review and assess the use of behavioral health inpatient care

10.1.1 Concurrent review of hospital admission for behavioral health, including but not limited to a review of the appropriateness of the treatment plan and discharge plan, as well as profiling the course of treatment (i.e., length of inpatient stay).

10.1.1.1 Concurrent review pertains to:

- 10.1.1.1.1** All Fee for service admissions to OMH-licensed psychiatric units (all ages) in general hospitals (Article 28 hospitals);
- 10.1.1.1.2** Fee for service children and youth admitted to OMH licensed psychiatric hospitals (Article 31 hospitals);
- 10.1.1.1.3** 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;
- 10.1.1.1.4** Fee-for-service OASAS certified hospital (Art 28/32) or freestanding (Article 32 only) Part 818 Chemical Dependence Inpatient Rehabilitation Services; and
- 10.1.1.1.5** Fee for service OASAS Certified Part 816 Inpatient Detoxification Services (Article 28/32).

10.1.1.2 The Offices will require providers of these services to contact the BHO in a HIPAA /42 CFR Part 2 compliant manner within 24 hours of an inpatient admission for a behavioral health condition.

10.1.1.3 For each such admission, within 48-72 hours after admission, the BHO will contact the provider and review information on the individual's recent service utilization history for the purpose of assisting in the development of treatment and discharge plans. Information on recent service use will be drawn from Medicaid

claims which will be available to the BHO as well as additional data collected by the BHO.

- 10.1.1.4** The BHO will initiate subsequent discussions with the inpatient program for the purpose of monitoring the individual's status, and for the purpose of assessing the appropriateness of continuing inpatient care for longer stay individuals. The BHO will determine the intervals for such subsequent discussions and the criteria for determining the appropriateness of continued inpatient care, subject to the approval of OMH or OASAS, as appropriate. These will be discussed in the selection process document submission.
- 10.1.1.5** 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. The BHO will provide intended criteria as part of the selection process document submission.
- 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. 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.

10.1.2 Monitor discharge planning activities and facilitate timely connection to services post discharge.

- 10.1.2.1** 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.

Details of this task by covered population are as follows:

10.1.2.2 Activities for all covered populations and services:

- 10.1.2.2.1** By day 3 of admission for inpatient psychiatric programs and OASAS certified Part 816 inpatient detoxification programs; and within 21 days for OASAS certified Part 818 inpatient rehabilitation programs and continuing as necessary for all

programs, the BHO will monitor discharge planning activities. Calls may be concurrent with calls made for task 10.1.1. Monitoring will include but not be limited to:

- 10.1.2.2.1.1 Status of patient including diagnosis and expected length of stay;
 - 10.1.2.2.1.2 Status of treatment plan;
 - 10.1.2.2.1.3 Anticipated discharge date;
 - 10.1.2.2.1.4 Completion of assessment of physical and behavioral health needs;
 - 10.1.2.2.1.5 Determination if contact has been made with prior outpatient behavioral health and physical health provider(s) (if relevant);
 - 10.1.2.2.1.6 Determination if a contact has been made with an existing care manager, if appropriate (e.g., ACT, ICM, SCM, BCM, MATS, HCBS Waiver, and Health Home);
 - 10.1.2.2.1.7 Housing status of individual at the time of hospitalization and anticipated housing status post discharge; and
 - 10.1.2.2.1.8 Indication of consumer involvement (or family involvement for children under 18) with discharge plan.
- 10.1.2.2.2 The Offices will require the inpatient program to notify the BHO of a discharge by not later than the day following such discharge. If the BHO is not notified by 72 hours after the anticipated discharge date, the BHO will contact the inpatient unit for a status update.
- 10.1.2.2.3 For each discharge, the BHO will record the date of discharge, the name of the provider with whom an appointment has been made, the date of that appointment, and the time of the scheduled appointment.
- 10.1.2.3 Enhanced activities for a state-identified subset of individuals disengaged from care:**
- 10.1.2.3.1 The Offices will identify a subset of eligible adults deemed high need individuals who appear to be disengaged from needed services and will transmit this information to the BHO on a monthly basis.
 - 10.1.2.3.2 The BHO will assist the hospital in discharge planning for this cohort and in facilitating the receipt of timely and appropriate

services post discharge. Such proposed techniques are to be outlined in the Applicant's proposal.

10.1.2.3.3 The Offices will use Medicaid claims data to monitor the timeliness of engagement of services post discharge. The BHO may also elect to use Medicaid claims data or other means to monitor and determine whether services post discharge have occurred as planned.

10.1.2.4 Enhanced activities for individuals readmitted for inpatient care

10.1.2.4.1 For individuals readmitted for behavioral health reasons to the same hospital or another hospital's psychiatric inpatient unit within 30 days of prior discharge for psychiatric services and 45 days for substance abuse treatment, the BHO will conduct a clinical quality review of the implementation of the discharge plan.

10.1.2.4.2 The BHO will assist the hospital in developing a discharge plan that attempts to better engage the individual in outpatient care.

10.1.2.4.3 The State will use Medicaid claims data to monitor timeliness of engagement of services post discharge. The BHO may also elect to use Medicaid claims data or other means to monitor and determine whether services post discharge have occurred as planned.

10.1.2.5 Enhanced activities for individuals who have had multiple admissions for detoxification services

The BHO will identify patients who have 3 or more admissions for detoxification services in a calendar year and facilitate a referral for these patients to case management services such as MATS, or where available, a health home.

10.2 Task 2: Children's outpatient SED tracking

In order to achieve the goal of having all Medicaid recipients receive managed services within three years, it is essential that New York State fully understand the clinical conditions of children diagnosed as SED and treated in OMH licensed clinics. Therefore,

10.2.1 OMH licensed clinics that have been designated as Specialty Clinics will be required to notify the BHO of each new MMC child diagnosed as having a Serious Emotional Disturbance.

10.2.2 The BHO will track and report to OMH, the number of children so diagnosed. Such report will classify such data by clinic, diagnosis, functional limitations identified, and other relevant demographic information.

10.3 Task 3: Provider profiling:

10.3.1 The Offices will use Medicaid claims data to monitor key performance metrics including, but not limited to, inpatient length of stay, timeliness of engagement in services post discharge and readmission rates (see page 48). Metrics will be aggregated by The Offices at the BHO region and provider level (inpatient and outpatient). 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 claims data and reports with the BHO. The Offices and the BHO may use this information to identify problem areas for follow up.

10.3.2 Additional reports will be prepared by the BHO. The BHO will use the data it collects to profile providers with respect to: interactions between the BHO and the provider; characteristics and completeness of discharge plans; and effectiveness of interactions between the inpatient provider, the outpatient provider and, if relevant, the case manager or health home to implement the discharge plan. At a minimum, the BHO will collect the minimum data set specified in the Deliverables section (page 20) of this document in an electronic manner acceptable to and accessible by The Offices. The Offices and the BHO will consult with the Conference of Local Mental Hygiene Directors in the formatting of the reports to make them as useful as possible for county mental hygiene directors.

10.3.3 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 may elect to use Medicaid claims data and may combine those data with its own provider-level performance data to profile providers.

10.3.4 The BHO will share information on provider patterns of care with stakeholders, 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. Prior to release, the BHO will submit such data to The Offices for review and comment. Upon State consent, de-identified data will be made available to the public via posting on the BHO's website or through another site designated by The Offices for this purpose.

10.3.5 The BHO will meet with stakeholders and The Offices at least twice per year to provide information and updates on metrics and BHO deliverables.

These meetings can be concurrent with the quarterly meetings required in Task 10.4.

10.4 Task 4: Facilitate cross-system linkage

- 10.4.1** The BHO will work collaboratively and meet at least quarterly with stakeholders to coordinate activities, review performance data and to facilitate care planning for high need adults/children.
- 10.4.2** The BHO will encourage inpatient providers to develop linkages with health homes being created by New York State under the federal Affordable Care Act and with Regional Health Information Organizations in the region.
- 10.4.3** The BHO will proactively develop relationships with health homes being created by New York State under the federal Affordable Care Act and with Regional Health Information Organizations in the region
- 10.4.4** The BHO will monitor inpatient discharge plans to ensure that an individual's physical health needs are addressed. The BHO will facilitate linkage to physical health (subject to approval by OMH, OASAS and DOH) in collaboration with Medicaid Managed Care plans, as applicable.

XI. Additional Capabilities

For each capability area listed below, applicants are requested to provide information on their proposed approach to addressing the area, experience performing similar tasks, success in achieving area objectives, and organizational readiness to take on such tasks in New York State.

11.1 Capability 1: Define, engage and link cohorts of disengaged or high risk individuals to appropriate treatment

Applicants are requested to describe their capability to identify, engage and link individuals with behavioral health issues who do not currently have a provider responsible for coordinating services but whom, by virtue of their previous behavior, cost, or treatment needs, are at risk of poor outcome.

11.2 Capability 2: Reviews of outpatient engagement for post discharge follow up care

Applicants are requested to describe their capability to assess the reasons why people discharged from behavioral health inpatient settings did not engage in outpatient care post discharge. Applicants are further requested to address their capability to identify this population of individuals and attempt to engage them in care.

11.3 Capability 3: Suicide prevention

Applicants are requested to describe their capability to undertake suicide prevention activities for high need/high risk populations discharged from inpatient settings.

11.4 Capability 4: Reducing costs for people with high cost physical and behavioral health conditions.

Applicants are requested to describe their capability to reduce medical/surgical costs for people with SMI, SED and/or substance use who also have high cost physical health conditions.

11.5 Capability 5: Behavioral health emergency diversion/inpatient diversion

Applicants are requested to describe their capability to operate behavioral health emergency diversion/inpatient diversion programs.

XII. Staffing Requirements

The BHO will hire a sufficient number and mix of licensed, credentialed and non-licensed staff as may be necessary to effectively perform the tasks described in this selection process document including the ability to respond to clinically complex cases. Clinical contacts with hospital staff must be undertaken with appropriately licensed staff.

Inpatient providers must be able to speak with an adult or child psychiatrist as appropriate regarding the need for continued inpatient stay. Transmittals of notices of clinical determination that ongoing inpatient treatment is no longer needed must be approved by appropriate medical personnel. Other activities may be performed by non-licensed staff as appropriate.

The BHO will designate a single project director with executive authority to act on its behalf in the management of this project. The BHO must have a physical presence in the region and the project director must be located in the region.

A. Other staffing functions include:

1. Psychiatric consultation and oversight (adult and child).
2. Clinical oversight of staff and consultation on complex cases, including but not limited to staff with child and addiction specific experience and qualifications.
3. Sufficient quality assurance capacity to ensure completeness and quality of BHO case documentation and the ability to summarize such data electronically (i.e., free text fields alone are not electronically summarizable).

4. Sufficient IT/reporting capacity to develop and maintain data systems and produce data files and reports outlined in the Scope of Work and as otherwise required by The Offices.
5. Sufficient and appropriate call center capacity to make and take calls with hospitals, and providers and route appropriately.

Information on licensed and credentialed staff for New York State can be found at the following sites:

- [Office of the Professions](#) 
- [OASAS](#) 

XIII. BHO Quality Assurance Program

The BHO will develop and implement a Quality Assurance (QA) program that will support the project's goals. The design of the QA program will be subject to OMH and OASAS approval and will include the provision that the BHO monitor the quality of work performed under this agreement and that BHO will take corrective action as necessary to ensure that such work is timely, accurate, and conforms to the specifications set forth in this scope of work.

A. Key elements of the QA program include:

1. Tracking and reporting BHO's performance against standards identified as deliverables using measurement methodologies acceptable to The Offices.
2. An information system adequate, flexible, and responsive enough to generate accurate and timely reports to cover all key aspects of the program, including but not limited to the information domains listed herein.
3. Internal quality reviews of randomly selected, statistically adequate samples of BHO's records to assess the quality of care monitoring services, including the appropriateness of the discharge plans reviewed by the BHO and the BHO's efforts to insure the adequacy and appropriateness of these plans. Internal quality reviews will be conducted at least quarterly unless otherwise agreed to by The Offices. The BHO will include the results of such reviews in quarterly reports to The Offices.

XIV. Deliverables

The BHO must complete the following deliverables (See [Attachment E: Reporting and Task Deliverables](#)). These are divided between reporting deliverables and task specific deliverables. Reporting deliverables will help The Offices assess the performance of the BHO. Task deliverables are requirements associated with particular BHO tasks. These are detailed as follows:

A. Reporting Deliverables

1. The BHO will provide The Offices with all information necessary to assess the extent to which the tasks in the scope of work in the contract are completed satisfactorily. BHO must use report formats approved by The Offices when providing this information.
2. Quarterly reports of activities (see below) will be produced as well as an Annual Evaluation/Impact Analysis completed by the conclusion of month 13 of the project, summarizing performance and quality data from the first year of the project. Quarterly reports will be delivered to The Offices within 30 days after the close of a quarter. The BHO will propose an outline of the contents of the annual report by month 10 of the project for the Office's approval. Timing and content of the year 2 report will be mutually determined in consultation with the Conference of Local Mental Hygiene Directors after receipt and approval of the year 1 report.
 - a. The BHO is expected to prepare quarterly reports profiling the inpatient providers with whom they have interacted. These profiles will include but not be limited to:
 - i. The extent to which the inpatient provider contacted the BHO as required;
 - ii. The number of concurrent reviews completed and the findings of these reviews;
 - iii. The availability of hospital staff to provide information to the BHO;
 - iv. The extent to which the discharge plans addressed key areas relevant to the client;
 - v. Appropriateness of length of stay; and
 - vi. Summaries and recommendations based on the information presented.
 - b. For behavioral health admissions which were readmissions to any hospital within 30 days of prior discharge for psychiatric and 45 days for substance abuse, the BHO will provide quarterly reports containing a qualitative and quantitative summary of the reason(s) for readmission including an assessment of whether the readmission was attributable to:
 - i. Action/inaction of the discharging hospital;

- ii. Failure of the post discharge service providers to secure continuing engagement;
- iii. Unstable post discharge living situation;
- iv. Substance use;
- v. Discontinuation of psychotropic medication;
- vi. Other clinical problems (including physical health) related to the individual's illness; and
- vii. Other reasons.

This information will be reported on a provider-specific basis and in total for each region.

1. In addition to summary reports, the BHO will be required to provide a data file on a monthly basis containing specified data elements pertaining to BHO activities (see [Attachment D](#)). The file structure and means of submission will be specified by The Offices. This file will contain a record for each inpatient case reviewed in the reporting period.
2. A separate data file will be provided monthly based on the information collected from OMH licensed clinic programs with the Specialty Clinic designation. Such clinics will be required to notify the BHO of each new episode of care for each Medicaid Managed Care child designated as having a Serious Emotional Disturbance. Data to be collected include:
 - a. Program name
 - b. Child name
 - c. Medicaid ID
 - d. Date of birth
 - e. Primary diagnosis
 - f. Functional Impairment

B. Task Deliverables

Task 10.1: Monitor, review and assess the use of behavioral health inpatient care

1. 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.

2. For all covered populations, high need individuals who are disengaged from ambulatory care, and individuals readmitted to inpatient behavioral health units within 30 days of discharge for psychiatric and 45 days for substance abuse, report monthly the number of times the BHO reviewed the components of the discharge plan with the hospital.
3. For all covered populations, high need individuals who are disengaged from ambulatory care and individuals readmitted to inpatient behavioral health units within 30 days of discharge for psychiatric and 45 days for substance discharge, report on a monthly basis the number of times the hospital confirmed that it has provided the outpatient providers identified in the discharge plan with summaries of the patient's treatment and discharge plan prior to the first outpatient appointment.
 - a. The hospital stating that such a plan has been sent will be sufficient proof that this has occurred.
4. For all covered populations, the BHO will report data to The Offices on a monthly basis regarding anticipated housing status immediately post discharge (e.g., return to pre-admission housing versus new housing, housed with family, foster care, residential treatment program, own apartment, shelter), using categories approved by The Offices.
5. For all covered populations, the BHO will report data to The Offices on a monthly basis regarding the date of discharge, the name of the provider with whom an appointment has been made, the date of that appointment, and the time of the scheduled appointment.

Task 10.2: Children's outpatient SED tracking

1. The BHO will create and maintain a database to track new episodes of care for children in designated specialty clinics.
2. Data will be provided to the State quarterly along with a summary report.

Task 10.3: Provider profiling:

1. The BHO will provide a summary report to The Offices and respective LGUs within 30 days after each bi-annual stakeholder meeting.
2. The BHO will have a website within one month of contract execution and will post provider profile data on a quarterly basis.

Task 10.4: Facilitate cross-system linkages

1. The BHO will work collaboratively and meet at least quarterly with stakeholders to coordinate activities, review performance data and to facilitate care planning for high need adults/children.

2. Data will be provided to The Offices quarterly on the number of referrals made by behavioral health inpatient units to traditional Medicaid Managed Care plans or network treatment providers for individuals whose physical health services are covered by these plans.

XV. Behavioral Health Systems Evaluation

In addition to the BHO deliverables shown above in Section 10, this Phase I selection process provides The Offices with the opportunity to test and evaluate various global systems metrics. For general systems evaluation, The Offices will use Medicaid claims data to monitor key system performance metrics. These metrics will be aggregated by The Offices at the BHO region and provider level. Separate analyses will be conducted for those with readmissions and for high need individuals who are disengaged from ambulatory care.

The State will share Medicaid claims data and these reports with the BHO (the BHO will be subject to restrictions on re-disclosure of patient information to be detailed in the HIPAA Business Associates Agreement). The Offices will also receive data from the BHO and match that with Medicaid data to calculate metrics such as the proportion of persons keeping a first post hospital follow-up appointment as scheduled. Aggregate data will be provided to local government and other stakeholders through periodic meetings and other means.

Additional metrics will be tracked and reported by the BHO. The BHO will use the data it collects to profile providers with respect to interactions between the BHO and the provider and to assess the characteristics and completeness of discharge plans against the required components of the discharge plans as defined in [Attachment D](#).

Additional metrics and deliverables will be developed for any specific pilot projects funded as described in the Additional Capabilities section.

Based on data received from the BHO and from Medicaid claims data, The Offices will analyze several domains of system performance. These areas are contained in the chart in the [Appendix F](#).

XVI. Timeframe for Implementation

The BHOs is anticipated to begin operation by October 1, 2011. Applicants must be fully operational by three months after the date of the signed contract.

XVII. BHO Development and Submission Instructions

A. Submission Requirements

The proposal shall not exceed 50 pages, plus attachments. It shall be typed on paper that measures 8 ½ by 11 inches. Type size shall be no smaller than twelve (12) points, with no less than single line spacing. Page margins shall be no less than one (1) inch. The name of the organization submitting the proposal shall be noted on each page of the proposal, including the title page.

The Applicant is to deliver 7 hard copies of the proposal. Copies should also be accompanied by a USB memory device with a file protected electronic copy of the printed materials readable in Adobe Acrobat and Microsoft Word.

Proposals submitted for funding under this selection process must include all of the following components, in the following order:

1. Completed Transmittal Form

2. Executive Summary (maximum length 3 pages)

The Executive Summary should concisely describe how the entity will accomplish the scope of work contained in Section 10 of this selection process document including: experience, overall approach, resources required and anticipated outcomes.

3. Organizational Information

a. Applicant Qualifications and Experience

- i. Describe any relevant managed behavioral health, administrative services, and/or similar contracts in behavioral health the Applicant currently holds or has held within the past five years that demonstrate the Applicant's qualifications to perform the functions that comprise the required tasks in the scope of work. Identify any pending contracts. Provide a list of all public sector managed behavioral health care contracts currently active and of all public sector managed behavioral health care or health care contracts terminated within the past five (5) years. For each contract listed, provide a brief description of the size and scope of work and a contact person. Additionally, the Applicants should describe their experience to address the ["Additional Capabilities"](#) identified in this Selection Process document.
- ii. Disclose any previous (in the past five years) or currently pending litigation or administrative action taken in any jurisdiction that relates to the selection process document or operation of managed health, behavioral health, or human services programs that was initiated by or taken against the Applicant or any related organization or partnership in which the Applicant has five percent or more ownership or control interest.

- iii. Provide information regarding any instance in which the Applicant or related organization(s) or partnership in which the Applicant has five percent or more ownership or control interest, or directors, members, officers, partners, limited liability company managers, or shareholders have ever been suspended or excluded from any local, State, or federal government program for any reason.

b. Corporate Structure

- i. Provide an attachment that identifies each existing or proposed member of the Board of Directors, as well as any individual with five percent or more ownership or control interest in the Applicant. Specify which members are residents of New York State.
- ii. 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.

c. Key Personnel

Provide an attachment with an organizational chart and description of organizational structure, lines of supervision, and management for the BHO. Describe the day-to-day responsibility for key tasks, and list the names, titles, qualifications, expertise, and auspices of key personnel.

d. Financial Standing

Provide an attachment with copies of the most recent Certified Public Account financial statements, including notes, to demonstrate good financial standing.

4. Budget

- a. Complete Appendix B, **Operating Budget Form**, detailing all expense **components** that make up total operating expenses, including staffing ratios-to-required tasks. The budget should detail all fixed and variable costs including administrative and overhead charges and any costs that are being allocated from the corporate entity.

- b. For each required task, include local direct and local indirect staff, functions and costs (only related to the project) and identify the functions and staff and costs necessary for the project performed at an out-of-state location. If included in the general corporate “indirect rate”, or equivalent, please identify the portions of that rate these functions represent.
- c. Include supporting documentation and/or justification for the budgeted value of each category and task ([Appendix B1, Budget Narrative](#)).
- d. For successful applications, The Offices expect the total costs to be within the following range for each region. (Do not include any expenses for additional capacities in the scope of work).

Regional Cost Parameters

Region	Expected Budget Parameters
Central	\$1,050,000 to \$1,400,000
Hudson River	\$2,100,000 to \$2,800,000
Long Island	\$1,650,000 to \$2,200,000
New York City	\$5,400,000 to \$7,200,000
Western	\$1,300,000 to \$1,700,000

5. Implementation Plan

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.

6. Program Description and Staffing Requirements

For this section, please describe how you will complete and staff each task. Please answer each question that is posed below.

6.1. Required Tasks: (Numbering crosswalks to Section 10, Scope of Work)

10.1 Task 1: Monitor, review and assess the use of behavioral health inpatient care

10.1.1 Concurrent review

- A. Identify how the Applicant will work with behavioral health inpatient programs to help ensure contact within 24 hours for each fee-for-service admission.
- B. Describe the procedures and criteria the Applicant will use for performing the review of individuals as follows:

- a. Initial review within 48-72 hours and as needed thereafter for psychiatric inpatient;
 - b. Initial review within 48-72 hours of all admissions to OASAS certified Part 816 hospital-based Inpatient Detoxification programs and OASAS certified hospital or freestanding Part 818 Inpatient Rehabilitation programs; and
- C. Describe how fee-for-service behavioral health inpatient admission would be tracked; what information will be collected?
- D. The Applicant will describe the mechanism for assessing the appropriateness of inpatient level of care on initial and concurrent review including (but not limited to) the following clinical domains. 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:
 - i. Suicide risk assessment
 - ii. Potential for violence or danger to others
 - iii. Inability to live safely within the community due to acute psychiatric symptoms
 - c. Active Treatment and Discharge Planning
 - i. Pharmacologic:
 - ii. Psychosocial
 - iii. Substance use
 - d. Housing Status
- E. What process and staffing will the Applicant use:
- a. To contact hospital/program within the first 48-72 hours of all fee-for-service (as described above) behavioral health admissions to review information on recent Medicaid service;
 - b. For psychiatric admissions, to monitor ongoing status and discharge plan for longer stay individuals; and at what frequency these contacts will be initiated; and
 - c. For chemical dependence admissions (all), to monitor initial assessment, and at intervals

determined (the 3rd day for detoxification episodes and within 21 days for rehabilitation episodes) to monitor ongoing status and discharge plans for longer stay individuals.

- d. The Applicant will submit the staff qualifications for those doing inpatient clinical reviews.
- e. Describe what criteria the Applicant use and what will be the interval for monitoring the ongoing status and appropriateness of inpatient stays for long stay individuals.

10.1.2 Monitor discharge planning activities and facilitate timely connection to services post discharge.

- A. Describe the methods the Applicant will utilize to assist in the treatment planning and discharge functions including the number and qualifications of the staff that will be assigned to monitor discharge planning activities.
- B. For people readmitted for behavioral health reasons to any hospital within 30 days of discharge for psychiatric and 45 days for substance abuse, describe the process and criteria the Applicant will use to conduct a clinical quality review of the discharge plan and assist the hospital, as necessary, in developing a discharge plan that better engages the individual in outpatient care.
 - a. Include the proposed Standards of Care to be used by the Applicant.
- C. For high need individuals who are disconnected from care, describe the process and criteria the Applicant will use to conduct a quality review of the previous discharge plan and assist the hospital, as necessary, in developing a discharge plan that better engages the individual in outpatient care including case management, ACT or health homes if relevant.
- D. For patients who have 3 or more detox episodes in a calendar year, describe the process and criteria the Applicant will use to facilitate referral for these patients to case management services such as MATS or where available, a health home.
- E. Describe the ways in which Medicaid claims data can assist with this task.

10.2 Task 2: Children's outpatient SED tracking

- A. Describe how Applicant will create a database to track by program, diagnosis, functional limitations identified and other relevant demographic information, the number of children diagnosed with SED by “Interim Specialty Clinics”.

10.3 Task 3: Profile providers

- A. Detail the Applicant’s plan to provide additional reports and use the data it collects (including data on admissions to and discharges from inpatient settings) to profile providers regarding provider interactions with the BHO and the characteristics and completeness of discharge plans.
- B. Describe how, and with what kind and number of experienced staff, will the Applicant collect the required data in an electronic manner acceptable to and accessible by The Offices.
- C. As part of the plan, indicate whether or not the Applicant will also elect to use Medicaid claims data and combine those data with its own provider-level performance data to profile providers. If so, provide details on how this will be done.
- D. Describe how the Applicant will share information on provider patterns of care with respective local governmental unit(s), participating providers, consumer and family groups, and health homes designated in the BHO’s region.
- E. What would the Applicant propose as the best way for The Offices and the BHO to meet with stakeholders at least two times per year to provide information and updates on metrics including the performance of the BHO?

10.4 Task 4: Facilitate cross-system linkage

- A. Describe the Applicant’s plan to engage in discussions with local governmental units, physical and mental health providers, insurers, and other appropriate organizations on a regular (at least quarterly) basis to:
 - a. Coordinate activities
 - b. Review performance data
 - c. Facilitate care planning for high need adults and children
- B. How, and with what kind and number of experienced staff, will the Applicant monitor inpatient discharge plans to ensure that they address an individual’s physical needs?

- C. How, and with what kind and number of experienced staff, does the Applicant plan to facilitate linkage to physical health care (subject to approval by OMH, OASAS, and DOH) in collaboration with Managed Care Plans as applicable?

6.2. Additional Capabilities_(numbering crosswalks to Section 11, Additional Capabilities)

- A. For each capability area listed below, please provide information on your approach to addressing the issue, experience performing similar tasks, success in achieving your goals, types of resources required, and organizational readiness to takes on such tasks in New York State.

11.1 Capability 1: Define, engage and link defined cohorts of disengaged or high risk individuals to appropriate treatment

Please address your capability to identify, engage and link those individuals with behavioral health issues who do not currently have a provider responsible for coordinating services but whom, by virtue of their previous behavior, cost, or treatment needs, are at risk of poor outcome.

11.2 Capability 2: Reviews of outpatient engagement for post discharge follow up care

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.

11.3 Capability 3: Suicide prevention

Please address your capability to undertake suicide prevention activities for high need/high risk populations discharged from inpatient settings.

11.4 Capability 4: Reducing costs for people with high cost physical and behavioral health conditions.

Please address your capability to reduce medical/surgical costs for people with SMI, SED and/or substance use who also have high cost physical health conditions.

11.5 Capability 5: Behavioral health emergency room diversion/inpatient diversion

Applicants are requested to describe their capability to operate behavioral health emergency room diversion/inpatient diversion programs.

7. Reporting Requirements and Information Systems

- A. Please describe the capabilities of the information system that will be used to support this initiative. Include a discussion of the hardware, software and human resources that you will use to meet the data processing and reporting requirements of this selection process document.

8. Attachments

- A. Attachments are allowable only where noted, and when they are allowed, they are excluded from the established page limits. Such attachments must be marked clearly with the question number to which they refer.

XVIII. Review and Selection Criteria

The Commissioners of The Offices will select the applicant in each region that, in their discretion, they determine to be best suited to provide the services described for this program. Such determination will be based upon review of the applicants' submissions, and the extent to which they have demonstrated a familiarity with the mental and physical health needs of persons with significant behavioral health needs, the management of behavioral health services, and the integration of such services with physical health care. Consideration will be given to the manner in which applicants have demonstrated an understanding of the particular needs of children, high need individuals, and individuals who have been re-admitted to inpatient settings, and to the extent to which the applicants have demonstrated the ability to effectively, efficiently, and economically manage behavioral health services for such populations. Further consideration will be given to the extent to which the applicants have demonstrated the ability to effectively, efficiently, and economically integrate behavioral health and health services.

Applicants are required to have the requisite experience, expertise and financial resources to fulfill program responsibilities. Applicants must have demonstrated experience and expertise in directly managing/coordinating the full range of required health services, including behavioral and physical health services, for individuals and populations with significant behavioral health needs, including but not limited to children and adolescents, individuals with co-occurring mental health and substance use issues, and individuals with repeated hospitalizations for behavioral health needs.

The commissioners will select only such applicants as have demonstrated that their directors, sponsors, members, managers, partners or operators have the requisite character, competence and standing in the community, and are best suited to serve the purposes of this program.

Attachment A: Data Book

Applicants can find data to assist in developing the pricing and staffing for this solicitation by selecting the following links

[Directions](#) (PDF)

Tables ([Microsoft Excel 2007 Format](#) | [PDF](#))

Attachment B: BHO Statute – Chapter 59 of the laws of 2011, Part H Section 42.d

Notwithstanding any inconsistent provision of law, rule or regulation to the contrary, for the period April 1, 2011 through March 31, 2013, the commissioners of the office of mental health and the office of alcoholism and substance abuse services, in consultation with the commissioner of health and with the approval of the division of budget, shall have responsibility for jointly designating regional entities to provide administrative and management services for the purposes of prior approving and coordinating the provision of behavioral health services, and integrating behavioral health services with other services available under the medical assistance program, for recipients of medical assistance who are not enrolled in managed care, and for approval, coordination, and integration of behavioral health services that are not provided through managed care programs under the medical assistance program for individuals regardless of whether or not such individuals are enrolled in managed care programs. Such regional entities shall also be responsible for safeguarding against unnecessary utilization of such care and services and assuring that payments are consistent with the efficient and economical delivery of quality care.

In exercising this responsibility, the commissioners of the office of mental health and the office of alcoholism and substance abuse services are authorized to contract, after consultation with the commissioner of health, with regional behavioral health organizations or other entities. Such contracts may include responsibility for: receipt, review, and determination of prior authorization requests for behavioral health care and services, consistent with criteria established or approved by the commissioners of mental health and alcoholism and substance abuse services, and authorization of appropriate care and services based on documented patient medical need.

Notwithstanding any inconsistent provision of sections 112 and 163 of the State finance law, or section 142 of the economic development law, or any other law, commissioners of the office of mental health and the office of alcoholism and substance abuse services are authorized to enter into such contract or contracts without a competitive bid or request for proposal process; provided, however, that the office of mental health and the office of alcoholism and substance abuse services shall post on their websites, for a period of no less than thirty days: a description of the proposed services to be provided pursuant to the contractor contracts; the criteria for selection of a contractor or contractors; the period of time during which a prospective contractor may seek selection, which shall be no less than thirty days after such information is first posted on the website; and the manner by which a prospective contractor may seek such selection, which may include submission by electronic means. All reasonable and responsive submissions that are received from prospective contractors in timely fashion shall be reviewed by the commissioners of the office of mental health and the office of alcoholism and substance abuse services. The commissioners of the office of mental health and the office of alcoholism and substance abuse services, in consultation with the commissioner of health, shall select such contractor or

contractors that, in their discretion, are best suited to provide the required services.

The commissioners of the office of mental health, the office of alcoholism and substance abuse services and the department of health, shall have the responsibility for jointly designating on a regional basis, after consultation with the city of New York's local governmental unit, as such term is defined in the mental hygiene law, and its local social services district, and with the prior consultation of other affected counties, a limited number of specialized managed care plans, special need managed care plans, and/or integrated physical and behavioral health provider systems capable of managing the behavioral and physical health needs of medical assistance enrollees with significant behavioral health needs. Initial designations of such plans or provider systems should be made no later than April 1, 2013, provided, however, such designations shall be contingent upon a determination by such State commissioners that the entities to be designated have the capacity and financial ability to provide services in such plans or provider systems, and that the region has a sufficient population and service base to support such plans and systems.

Once designated, the commissioner of health shall make arrangements to enroll such enrollees in such plans or integrated provider systems and to pay such plans or provider systems on a capitated or other basis to manage, coordinate, and pay for behavioral and physical health medical assistance services for such enrollees.

Notwithstanding any inconsistent provision of section 112 and 163 of the State finance law, and section 142 of the economic development law, or any other law to the contrary, the designations of such plans and provider systems, and any resulting contracts with such plans, providers or provider systems are authorized to be entered into by such State commissioners without a competitive bid or request for proposal process.

Oversight of such contracts with such plans, providers or provider systems shall be the joint responsibility of such State commissioners, and for contracts affecting the city of New York, also with the city's local governmental unit, as such term is defined in the mental hygiene law, and its local social services district. Provided, however, if this chapter appropriates sufficient additional funds to provide coverage for behavioral health care and services under the program of medical assistance for needy persons without the savings to be achieved by contracting for the prior authorization of such services, then the provisions of this paragraph shall not apply and shall be considered null and void as of March 31, 2011.

Attachment C: Schedule of MMC and FFS Benefits – With Major Changes Proposed under Medicaid Redesign Team (MRT) Initiatives

	Managed Care Services	TANF/Safety Net	SSI Enrollees	Dual Enrollees (Medicaid/Medicare) – Not Included in Year 1¹
1.	All Physical Health Services, including: Inpatient Hospital Services, Outpatient Services, Laboratory and Radiology, Physical Rehabilitation, Home Health, Private Duty Nursing, Hospice, Emergency Services, Foot Care; Eye Care; Durable Medical Equipment; Audiology; Transportation; Prosthetics and Orthotics, Dialysis, and Residential Health Care Facility Services (RHCF- except for those in permanent placement).	Current: Covered under MMC plans, with the exception of hospice, which is covered by FFS and transportation, which is an optional benefit covered by FFS if not covered by the MMC plan. Note: Under proposed MRT initiatives, emergency and non-emergency transportation will be	Current: Covered under MMC plans, with the exception of hospice, which is covered by FFS and transportation, which is an optional benefit covered by FFS if not covered by the MMC plan. Note: Under proposed MRT initiatives, emergency and non-emergency transportation will be carved out on a phased-in	Current: Some services listed are covered by Medicare with Medicaid paying cost sharing. Some are covered under Medicaid FFS, except for enrollees in Medicaid Advantage, MAP, Managed Long Term Care ² and PACE. Note: A proposed MRT initiative will align Medicare Part B clinic coinsurance with Medicaid coverage

¹ Medicare benefits could be provided on FFS-basis or through a Program of All Inclusive Care for the Elderly (PACE) or Medicare Advantage Plan (MAP) which also would include those enrolled in Medicaid Advantage and Medicaid Advantage Plus.

² Managed Long Term Care partial capitation plans do not cover inpatient or physician services. The benefit package includes home care, adult day health care, personal care, DME including medical/surgical supplies, enteral and parenteral formula, hearing aid batteries, prosthetics, orthotics and orthopedic footwear, personal emergency response systems, non-emergent transportation, foot care, dental services, optometry/eyeglasses outpatient rehabilitation therapies, nutrition counseling and private duty nursing.

Managed Care Services	TANF/Safety Net	SSI Enrollees	Dual Enrollees (Medicaid/Medicare) – Not Included in Year 1 ¹	
	<p>carved out on a phased-in basis by region; physical, occupational and speech therapy will be limited to 20 visits each per year as of 10/1/11; permanent stays in RHCs will be covered as of 10/1/12; prescription footwear and compression stocking benefits will be reduced effective 4/1/11; Personal Care Services (except CDPAP) will be covered by plans effective 8/8/11.</p>	<p>basis by region; physical, occupational and speech therapy will be limited to 20 visits each per year as of 10/1/11; permanent stays in RHCs will be covered as of 10/1/12; prescription footwear and compression stocking benefits will be reduced effective 4/1/11; Personal Care Services (except CDPAP) will be covered by plans effective 8/8/11.</p>	<p>and rates, contingent upon federal approvals.</p>	
2.	<p>Prescription and Non-Prescription (OTC) Drugs, Medical Supplies, and Enteral Formula</p>	<p>Current: Covered under FFS; infusion/injection drugs covered by MMC as part of a clinic or office visit, except for certain injectable mental health drugs (Risperdal, Invega, and Zyprexa) and hemophilia blood factors which are covered under FFS.</p> <p>Note: Under an MRT</p>	<p>Current: Covered under FFS; infusion/injection drugs covered by MMC as part of a clinic or office visit, except for certain injectable mental health drugs (Risperdal, Invega, and Zyprexa) and hemophilia blood factors which are covered under FFS.</p> <p>Note: Under an MRT</p>	<p>Current: Most prescription drugs covered by Medicare Part D. Certain prescription drugs and non-prescription covered under Medicaid FFS, except for PACE. For MAP, PACE and MLTC certain medical supplies and enteral formula are covered by the plan.²</p> <p>Note: Under an MRT</p>

	Managed Care Services	TANF/Safety Net	SSI Enrollees	Dual Enrollees (Medicaid/Medicare) – Not Included in Year 1¹
		initiative, prescription drugs, except for hemophilia blood factors, will be a covered benefit under MMC as of 10/1/11. Other MRT initiatives will adjust the reimbursement rate for hemophilia blood products and apply medical necessity criteria to enteral formula.	initiative, prescription drugs, except for hemophilia blood factors, Risperdal, Invega and Zyprexa, will be a covered benefit under MMC as of 10/1/11. Other MRT initiatives will adjust the reimbursement rate for hemophilia blood products and apply medical necessity criteria to enteral formula.	initiative, coverage for drugs available to dual eligible beneficiaries through their Medicare Part D plans will be eliminated.
3.	Smoking Cessation Products	Current: Not covered under MMC. Available under FFS. Note: Under an MRT initiative, smoking cessation products will be a covered benefit as of 10/1/11	Current: Not covered under MMC. Available under FFS. Note: Under an MRT initiative, smoking cessation products will be a covered benefit as of 10/1/11	Current: Smoking cessation counseling covered by Medicare.
4.	Dental Services	Current: Covered by MMC if included in MMC provider benefit package; if not included in MMC benefit package, available as FFS.	Current: Covered by MMC if included in MMC provider benefit package, if not included in MMC benefit package, available as FFS.	Current: Covered under FFS, except for enrollees in MAP, Managed Long Term Care ² and PACE. Some Medicare Advantage plans cover some dental

	Managed Care Services	TANF/Safety Net	SSI Enrollees	Dual Enrollees (Medicaid/Medicare) – Not Included in Year 1¹
		Note: An MRT initiative will reduce FFS fees to match those paid by MMC, for high volume dental services.	Note: An MRT initiative will reduce FFS fees to match those paid by MMC, for high volume dental services.	services. For Medicaid Advantage, dental services are an optional benefit outside NYC. Note: An MRT initiative will reduce FFS fees to match those paid by MMC, for high volume dental services.
5.	Routine Mental Health Services other than those specifically listed as 6-10, below, including inpatient mental health services (voluntary or involuntary admissions) and outpatient services, including but not limited to assessment, stabilization, discharge planning, verbal therapies, education, case management and crisis intervention.	Current: Covered under MMC plans.	Current: Not covered under MMC when provided by mental health practitioner. Available as FFS.	Current: Medicare covers limited inpatient services (190 days lifetime) and many outpatient mental health services (with a cost share), otherwise covered by Medicaid FFS, except for PACE.

	Managed Care Services	TANF/Safety Net	SSI Enrollees	Dual Enrollees (Medicaid/Medicare) – Not Included in Year 1¹
6.	Detoxification Services	Current: Covered under MMC plans.	Current: Covered under MMC plans.	Current: If not covered by Medicare under Mental Health services, available as FFS Medicaid. PACE covers in plan.
7.	Chemical Dependence Inpatient Rehabilitation and Treatment Services	Current: Covered under MMC plans.	Current: Not covered under MMC. Available as FFS.	Current: If not covered by Medicare under Mental Health services, available as FFS Medicaid. PACE covers in plan.
8.	Chemical Dependence Outpatient (in OASAS certified clinics – outpatient CD services in other settings covered by plan)	Current: Not covered under MMC. Available as FFS.	Current: Not covered under MMC. Available as FFS.	Current: If not covered by Medicare under Mental Health services, available as FFS Medicaid. PACE covers in plan.
9.	Methadone Maintenance Treatment Program (MMTP)	Current: Not covered under MMC. Available as FFS.	Current: Not covered under MMC. Available as FFS.	Current: Covered under FFS, except for enrollees in PACE.
10.	Specialized Mental Health Services, not covered by MMC, e.g., Intensive Psychiatric Rehabilitation Treatment Programs (IPRT); Day Treatment; Home and Community	Current: Not covered under MMC. Available as FFS.	Current: Not covered under MMC. Available as FFS.	Current: Covered under FFS, except for enrollees in PACE.

Managed Care Services	TANF/Safety Net	SSI Enrollees	Dual Enrollees (Medicaid/Medicare) – Not Included in Year 1¹
Based Services Waivers, SPMI /SED Case Management; Services for Seriously Emotionally Disturbed Children (SED); Assertive Community Treatment (ACT), Residential Treatment Facility , Community Residence, Teaching Family Homes, etc.			

Attachment D: Monthly Reporting Data for Hospital Admissions and Discharges

The following list is illustrative of the data that The Offices wish to receive. Full specification of the data elements and means of transmittal will be determined during the implementation process post selection.

- A. Patient name
- B. Patient Date of Birth
- C. Patient's County of Residence
- D. Medicaid ID #
- E. Admission Date
- F. Hospital Name
- G. Hospital ID number
- H. Diagnosis (including all 5 axes)
- I. Date the BHO was notified of the admission
- J. Date of first call to the hospital
- K. Was this a readmission within 30 days of inpatient discharge for psychiatric and 45 days for substance abuse?
- L. Is the person identified as a member of the high need population?
- M. Components of the discharge plan:
 - 1. If applicable was the care manager contacted? (Care manager to include ACT, ICM, SCM, BCM, MATS, HCBS, and Health Home)
 - 2. Were current or prior outpatient and care coordination providers contacted?
 - 3. For readmissions, were the factors that led to the readmission addressed in the discharge plan?
 - 4. Housing type at time of hospitalization
 - 5. Housing type at discharge
 - 6. Indication of consumer involvement (or family involvement for children' under 18) in the discharge plan
 - 7. Were physical health care needs identified that require post hospital follow-up?
 - 8. If yes, was appointment for physical health services post discharge made?
 - 9. If yes, date of appointment and name of provider

10. Date of appointment for behavioral health treatment # 1, type of treatment, name and ID of provider
11. Date of appointment for behavioral health treatment # 2, type of treatment, name and ID of provider
12. Date and appointment for care coordination provider, if applicable
13. Date case summary was sent to outpatient provider?
14. Was a SPOA application submitted? If yes, for what service?
15. Was an AOT order sought?
16. Actual Discharge date
17. Was a notice of clinical determination sent?

Attachment E: Reporting and Task Deliverables

The BHO must complete the following deliverables which are divided between reporting deliverables and task specific deliverables. Reporting deliverables will help The Offices assess the performance of the BHO. Task deliverables are requirements associated with particular BHO tasks.

REPORTING DELIVERABLES	Monthly	Quarterly	Annually
Profiling Inpatient Providers with whom the BHO has interacted:		√	
• Extent to which the inpatient provider contacted the BHO as required		√	
• Number of concurrent reviews completed and the findings of these reviews		√	
• Availability of hospital staff to provide information to the BHO		√	
• Extent to which the discharge plans developed addressed key areas relevant to the client		√	
• Appropriateness of length of stay		√	
• Summaries and recommendations based on the information presented.		√	
Qualitative and quantitative summary of reasons for behavioral health admissions which were readmissions to any hospital (within 30 days of discharge for psychiatric and 45 days for substance abuse) (by provider and in total by region):		√	
• Action/inaction of discharging hospital		√	
• Failure of the post discharge service providers to secure continuing engagement		√	
• Unstable post discharge living situation		√	
• Substance use		√	
• Discontinuation of psychotropic medication		√	
• Other clinical problems (including physical health) related to the individuals illness		√	
• Other reasons		√	

REPORTING DELIVERABLES	Monthly	Quarterly	Annually
Data file containing a record of each inpatient case reviewed in the reporting period. (Data is specified in Attachment D)	√		
Data file based on information collected from OMH licensed outpatient clinic programs with the “Interim Specialty Clinic” designation. Such clinics will be required to notify the BHO of each new episode of care for each Medicaid managed care child designated as Seriously Emotionally Disturbed. Data includes:	√		√
• Program Name			
• Child Name			
• Medicaid ID			
• Date of Birth			
• Primary Diagnosis			
• Functional Impairment			
Annual Evaluation/Impact Analysis - will summarize performance and quality data from the first year of the project. Timing and content for Year 2 report will be mutually determined in consultation with the Conference of Local Mental Hygiene Directors after receipt of the Year 1 report.			√ (One time, to be completed by month 13 of the project)
Outline of the Annual Evaluation/Impact Analysis			√ (One time, to be submitted to The Offices by month 10 of the project)

Task Deliverables	Monthly	Quarterly	Bi-Annually
Task 1: Monitor, review and assess the use of behavioral health inpatient care			
<ul style="list-style-type: none"> • Number of times the BHO provided inpatient staff with information on the patient's service history relevant to treatment and discharge planning within 48-72 hours of the client's admission 	√		
<ul style="list-style-type: none"> • For all covered populations, high need individuals who are disengaged from ambulatory care, and individuals readmitted to inpatient behavioral health units within 30 days of prior discharge for psychiatric and 45 days for substance abuse, report monthly the number of times the BHO reviewed the components of the discharge plan with the hospital. 	√		
<ul style="list-style-type: none"> • For all covered populations, high need individuals who are disengaged from ambulatory care and individuals readmitted to inpatient behavioral health units within 30 days of prior discharge for psychiatric and 45 days for substance abuse, report the number of times the BHO confirmed that the discharging hospital has provided the outpatient providers identified in the discharge plan with summaries of the patient's treatment and discharge plan prior to the first outpatient appointment (the hospital stating that such a plan has been sent will be sufficient proof that this has occurred) 	√		
<ul style="list-style-type: none"> • For all covered populations, BHO will report data regarding housing status immediately post discharge, using categories approved by The Offices 	√		
<ul style="list-style-type: none"> • For all covered populations, BHO will report data regarding the date of discharge, the name of the provider with whom an appointment has been made, the date of that appointment, and the time of the scheduled appointment 	√		

Task Deliverables	Monthly	Quarterly	Bi-Annually
Task 2: Children’s outpatient SED tracking			
<ul style="list-style-type: none"> • BHO will create and maintain a database to track new episodes of care for children in SED clinics 			
<ul style="list-style-type: none"> • Data will be provided to OMH with a summary report 	√	√	
Task 3: Profiling Providers			
<ul style="list-style-type: none"> • The BHO will provide a summary report to The Offices and respective LGUs within 30 days of each bi-annual stakeholder meeting 			√
<ul style="list-style-type: none"> • BHO will have a website to post profile data within one month of award 	√ (One time within one month of award)		
<ul style="list-style-type: none"> • BHO will post profile data on website 		√	
Task 4: Facilitate cross-system linkages			
<ul style="list-style-type: none"> • Data will be provided to The Offices on the number of referrals made by behavioral health inpatient units to traditional Medicaid managed care plans or network treatment providers for individuals whose physical health services are covered by these plans 		√	
<ul style="list-style-type: none"> • The BHO will work collaboratively and meet at least quarterly with stakeholders to coordinate activities, review performance data and to facilitate care planning for high need adults/children. 		√	

Attachment F: Mental Health System Metrics

The table below lists systems metrics that will be **evaluated by The Offices**. This list may be modified or expanded and specific performance expectations specified during the implementation phase of the project.

Performance Metrics	
Domain: Access	
<i>Performance expectation: Access to appropriate behavioral health services will be maintained as managed care strategies are implemented</i>	
Metric	Data Source
<p>X% of individuals access outpatient mental health care.</p> <p>Y% of individuals utilize only inpatient or emergency room services for mental health treatment (seek to reduce the proportion with this pattern of service use)</p>	Medicaid Claims and Encounters
Domain: Engagement in Treatment and Continuity of Care	
<i>Performance expectation: Individuals who have been ill enough to be hospitalized will be engaged in appropriate follow up services promptly upon discharge</i>	
Metric	Data Source
<p>X% of individuals discharged from a mental health hospitalization will have an outpatient visit within Y days of discharge</p> <p>X% of individuals discharged from a detox programs will have a visit in a non-crisis service within 30 days of discharge.</p> <p>X% of individuals discharged from inpatient rehab will have a non-crisis visit in a lower level of care within 30 days of discharge</p>	Medicaid Claims and Encounters
For X% of discharges where the discharge plans indicated that an outpatient appointment had be scheduled, Medicaid claim/encounter data confirms that the follow-up appointment occurred.	BHO collected data on the content of the discharge plan and Medicaid Claims and Encounters
<p>X% of individuals discharged from a mental health hospitalization have a second outpatient visit within Y days of discharge</p> <p>X% of patients who have an outpatient visit within 30 days of discharge from detox or inpatient will have a follow-up</p>	Medicaid Claims and Encounters

appointment within y days of discharge	
N% of those discharged complete X outpatient visits within Y months N% of those individuals who have an outpatient visit will complete X number of visits within Y months	Medicaid Claims and Encounters
X% of persons discharged from a MH inpatient stay who were enrolled in targeted case management and/or health home prior to the admission will receive targeted case management and/or health home services in the month post discharge.	Medicaid Claims and Encounters
X% of persons discharged from a MH inpatient stay who were enrolled in ACT prior to the admission will receive ACT services in the month post discharge.	Medicaid Claims and Encounters
X% of adults discharged from a mental health hospitalization will fill a psychotropic script within 30 days of discharge and Y% of such adults will refill that prescription or a new psychotropic prescription within 100 days of discharge. At least x% of adults discharged from a Part 816 detoxification or a Part 818 inpatient rehabilitation will fill a prescription (or have a claim) for an addiction medication – y% of these will have a second claim or fill a prescription within 30 days of discharge.	Medicaid Claims and Encounters
N% of children discharged from a mental health hospitalization will fill a psychotropic script within 30 days of discharge and Y% of such children will refill that prescription or a new psychotropic prescription within 100 days of discharge.	Medicaid Claims and Encounters
For those hospitalized for a psychotic disorder, N% of those discharged fill a script for an antipsychotic medication within X days of discharge	Medicaid Claims and Encounters
For those hospitalized for a mood disorder, N% of those discharged fill a script for a mood stabilizer or antidepressant within X days of discharge For Part 818 inpatient rehabilitation and Part 816 detoxification hospitalizations with a diagnosed mood disorder will fill a prescription for a mood stabilizer or antidepressant within X days of D/C	Medicaid Claims and Encounters

For X% of recipients where the discharge plans indicate the need for physical health care linkage the person receives physical health services with Y days.	Medicaid Claims and Encounters
Performance expectation: <i>Inpatient length of stay will be of appropriate duration</i>	
OASAS – 95% meet criteria for continued stay at day 14.	
Length of stay will be reduced. Measures include: mean days, the median, total days, the number and the proportion of stays that exceed X days (getting at reducing long stay outliers).	Medicaid Claims and Encounters
Performance expectation: <i>Readmissions will decrease.</i>	
Fewer than X% of individuals discharged from a behavioral health hospitalization will be readmitted to any hospital for psych or substance abuse treatment within Z days of discharge	Medicaid Claims and Encounters
Readmission within 30 and 90 days of discharge will decrease by X% for individuals with FFS Medicaid and by Y% for Individuals at High Risk of Poor Outcomes.	Medicaid Claims and Encounters
Domain: Acceptability	
Performance expectation: <i>Post-discharge persons will be referred to services with providers that offer services which individuals find useful enough to come back a second time.</i>	
X% of individuals discharged from a mental health hospitalization who have a first outpatient appointment will keep a second appointment within Y days with the same provider.	Medicaid Claims and Encounters
X% of individuals discharged from a mental health hospitalization who have a first outpatient visit within 30 days of discharge will have a second visit with the same provider within 31 days of the first visit.	Medicaid Claims and Encounters

[Appendix A: Agency Transmittal Form](#)

[Appendix B: Operating Budget Form](#)

[Appendix B-1: Budget Narrative](#)