New York State Behavioral Health
Medicaid Managed Care Contracting Overview

Adam Falcone, JD, MPH, Feldesman Tucker Leifer Fidell LLP
Andrew Cleek, PsyD, McSilver Institute-UIBH.
Dan Ferris, MPA, McSilver Institute

MCTAC.info@nyu.edu
http://www.MCTAC.org
Managed Care TAC (MCTAC)
Overview

What is MCTAC?
MCTAC is a training, consultation, and educational resource center that offers resources to all mental health and substance use disorder providers in New York State.

MCTAC’s Goal
Provide training and intensive support on quality improvement strategies, including business, organizational and clinical practices to achieve the overall goal of preparing and assisting providers with the transition to Medicaid Managed Care.
MCTAC Overview (cont.)

MCTAC is partnering with OMH and OASAS to provide:

– Foundational information to prepare providers for Managed Care

– Support and capacity building for providers
  • tools
  • informational training & group consultation
  • assessment measures

– Information on the critical domain areas necessary for Managed Care readiness

– Aggregate feedback to providers and state authorities
Managed Care Technical Assistance Center
MCTAC hosted five in-person contracting forums between November 2014 and January 2015.

- Session 1: Rochester; November 14, 2014
- Session 2: Long Island; November 25, 2014
- Session 3: NYC; December 9, 2014
- Session 4: Albany; December 10, 2014
- Session 5: NYC; January 13, 2015

93% of attendees who completed feedback forms found these sessions to be useful.

MCTAC offered a webinar on December 17th featuring the plan perspective of Managed Care contracting presented by Harold Iselin and Whitney Phelps.
REGISTER NOW!
READINESS ASSESSMENT WEBINAR
FEBRUARY 26, 10AM-12PM

This webinar will include:

• The collective results of over 300 submitted readiness assessments measuring preparedness for the transition to Medicaid managed care.
• An overview of how participating agencies scored overall as well as in certain domains of the assessment.

Following the webinar, MCTAC will send participating agencies individualized reports containing their results.

Didn't submit a readiness assessment? MCTAC is still accepting submissions on a rolling basis and a second round of individualized reports will be sent back to agencies this spring.

Visit MCTAC.org/page/provider-readiness for more information
Visit **www.mctac.org** to view past trainings, sign-up for upcoming events, and access resources.

**Upcoming Events**

- **Tuesday, February 16, 2015**
  Contracting for Managed Care Webinar Overview and Office Hours, 10 am - 12 pm

- **Thursday, February 26, 2015**
  Readiness Assessment: Follow-up Webinar

Visit [mctac.info@nyu.edu](mailto:mctac.info@nyu.edu)

Follow @CTACNY
Adam J. Falcone, Partner -- Feldesman, Tucker, Leifer, Fidell

A partner in the health law practice group, Adam counsels clients on a wide range of health law issues, with a focus on fraud and abuse, reimbursement and payment, and antitrust and competition matters. Drawing on his extensive knowledge of health care policy and markets, Adam regularly speaks to groups across the country on managed care contracting, value-based payment methodologies, and health reform opportunities. In particular, he brings strategic counsel to clients that are responding to changes in their local marketplace, negotiating participating provider agreements, and seeking to establish provider networks such as Accountable Care Organizations.
NEGOTIATING MANAGED CARE CONTRACTS

from a POSITION of STRENGTH

Adam J. Falcone, J.D., M.P.H.
Feldesman Tucker Leifer Fidell LLP
This training is provided for general informational and educational purposes only and does not constitute legal advice or opinions. The information is not intended to create, and the receipt does not constitute, an attorney-client relationship between trainer and participant. For legal advice, you should consult an attorney.
Before you sign, use the P.E.N!

✓ Prepare
✓ Evaluate
✓ Negotiate
A party that recognizes its strengths has an advantage in achieving its objectives.
IDENTIFYING YOUR STRENGTHS

Assess Leverage

Increase Leverage or Value

Compete Based on Value
• **Self-Assessment Questions:**
  – Is the MCO required to include me in its network?
  – Is the MCO required to cover one or more of my services?
  – Is the MCO required to pay me a specific rate?

• **Get Answers! Examine the following:**
  - State insurance laws and regulations
  - Medicaid laws or regulations
  - MCO’s contract with the State Medicaid agency *(See Appendix B of these slides!)*
  - Insurance Exchange regulations and rules

• **Hint:** Key terms to look for: “provider network”, “network adequacy”, “network service”, “network contracting requirements,” and “minimum network standards”.
ASSESSING LEVERAGE: MARKET-BASED

• **Self-Assessment Questions:**
  – Does the MCO have alternatives if it does not contract with me?
  – Can the MCO afford to leave me out of its network?

• **Get Answers! Conduct a market analysis**
  ➢ What counties in New York State do I serve?
  ➢ What organizations furnish similar services to me?
  ➢ For each of my services, what percent of the market do I serve as compared to other organizations?

• **Hint:** Fewer providers = Greater leverage
  – Assess breadth and scope of services
  – Analyze market share
  – Consider brand and reputation
ASSESSING LEVERAGE: TIMING

• **Self-Assessment Questions:**
  - Is the MCO establishing a new product or provider network?
  
  - Is MCO facing critical deadlines in order to enter marketplace by a certain date?
    - Each Medicaid MCO must submit a detailed network plan for review and approval at least 120 days prior to start-up date. (RFQ § 3.7.B.)

• **Get Answers! Learn from:**
  - Managed care entities
  - Your trade and professional associations
  - Your peers
WHAT IS COMPETING ON VALUE?

Competing on value enhances your negotiating position because you offer something of greater value, as compared to other providers in the marketplace.
IDENTIFYING VALUE

• **Self-Assessment Questions:**
  - Can you offer potential cost-savings to the MCO through reductions in ER visits or inpatient admissions?
    - Adherence to antipsychotic medications
    - Better management of behavioral health or SUDs
    - Identification of undiagnosed behavioral health or SUDs?
  - For any of the above, can you quantify the savings?

• **Get Answers!**
  - Collect data and report on quality measures
  - Access data on total costs of care for your patients
IDENTIFYING VALUE

- **Self-Assessment Questions:**
  - Do you offer integrated physical and behavioral health care?
    - What model of integration?
    - Have you been designated as a health home?
  - Do you have written affiliation arrangements for the referral of patients with significant mental illness or substance use disorders from primary care providers?
  - Can you offer MCOs potential cost savings through ensuring appropriate coordination of care for your patients’ physical health conditions?
• **Self-Assessment Questions:**

  ➢ Are you willing to incur some downside financial risk that would otherwise fall upon the MCO?
    • Capitated payment for the provision of services furnished by your organization
    • Bundled payments or case rates for specific diagnoses or conditions
    • Shared savings and losses for total costs of care

  ![Image: YOU TAKE THE RISK](image-url)
COMPETING ON VALUE

• Communicate Your Value!

➤ Marketing materials that communicates the value you offer to MCOs

➤ In-person meetings with MCOs to describe cost and clinical outcomes

➤ Participation at conferences that highlight your achievements

➤ Informal networking events

➤ Community events
Collaborations with other providers through joint ventures or integrated provider networks may increase leverage in the marketplace, enhance your value, or both, thereby improving your negotiation position.
TYPES OF JOINT VENTURES

- Referral Arrangement
- Co-location Agreement
- Purchase of Services
- Merger

Primary Care Provider

Behavioral Health Provider

Joint Venture
TYPES OF PROVIDER NETWORKS

IPA
- Behavioral Health Provider
- Primary Care Provider

Behavioral Health Organization
- Behavioral Health Provider
- SUD Provider
- Behavioral Health Provider

Management Services Organization
- Behavioral Health Provider
- SUD Provider
- Behavioral Health Provider
Providers form networks for a variety of purposes:

- **Shared Support Services**
  - IT Support for Electronic Health Record (EHR)
  - Health Information Exchange (HIE)
  - Credentialing practitioners; exclusion/debarment background checks
  - Third-Party Billing

- **Managed care contracting**
  - Marketing network of health care providers
  - Facilitating managed care contracting
  - Negotiating capitated risk contracts
  - Negotiating shared savings arrangements
CAUTION: ANTITRUST RISKS

In general, providers must make independent, unilateral decisions on contractual terms and negotiate separately in order to comply with state and federal antitrust laws.
A strategy is simply a plan of action for accomplishing an objective.
1. Consider timeframe for review

2. Assemble your contract review team

3. Assemble documents

4. Assess the MCO’s Operational Performance

5. Assess the MCO’s Financial Stability
6. Review the Contract

- Do you understand what all provisions mean?
- What provisions disadvantage your organization from a financial, clinical, operational, or legal perspective?
- Are responsibilities for each party clearly stated and all terms defined?
- Does the contract include all of the relevant appendices and exhibits?
- Have you reviewed any policies, procedures and documents referenced in the contract?
- Have you reviewed any references to statutes, codes, regulations to know what they say?
- Is the contract consistent with all other applicable Federal and State legal requirements?
- Does the contract reflect sound business judgment?

(See Appendix A of these slides!)
7. Identify and **Prioritize** Issues

- Make a list of the issues you identified during the contract review process.
- Categorize each issue as follows:
  - **Red**: Critical issues that without addressing you cannot afford to proceed because the risks (not just financial) are unacceptable for the organization
  - **Yellow**: Significant issues that should be addressed before proceeding because they create undesirable risks for the organization
  - **Green**: Issues that ideally would be addressed prior to proceeding to reduce potential risks
Negotiation is discussion aimed at reaching an agreement.
NEGOTIATING THE CONTRACT

• **Educate**: Do not assume that the MCO’s representative understands your concerns.

• **Learn**: Respond with questions, rather than statements, and respond specifically to the MCO’s concerns.

• **Voice** options for mutual gain and generate a variety of possibilities before deciding what to do.

• **Insist** that resulting provisions be based on some objective standard.

• **State** the importance of maintaining an ongoing relationship.
NEGOTIATING THE CONTRACT

• If you did not resolve all of the **critical issues** to your satisfaction, consider:
  
  – whether this **one** MCO contract is essential to your operations
  
  – whether the risks of contracting outweigh the risks of not contracting with the MCO
  
  – whether you can terminate the contract early in the event that the financial or legal harm becomes too great to bear
  
  – whether you have any other options for achieving a better outcome, i.e., using an agent for negotiations
Managed care requires you to evaluate your position in the marketplace for behavioral health and SUD services.

Assess your strengths and weaknesses in the context of managed care
- Which organizations comprise your competitors for MCO contracts?
- Can you compete with other organizations on the basis of value?

What organizational strategies will lead to increased leverage and the ability to compete on value in the managed care marketplace?
- Consider pursuing collaborations with other providers, including the formation of integrated networks for shared services and managed care contracting

Initiate conversations with MCOs about payment methodologies that support the delivery of quality services and lower overall costs.
Appendix A

Contract Review
CONTRACT REVIEW

- **Scope of Services.** Does the contract cover the full range of services you provide, or at least those you wish to provide?
- **Covered Services.** Does the contract place any unreasonable limits on how you may provide services?
- **Timely Claims.** Does the contract make the MCO’s denial of late claims discretionary rather than mandatory?
- **Prompt Payment.** Does the contract set forth a prompt payment provision that reflects New York’s Prompt Payment Law?
- **Correction of Overpayments and Underpayments.** Does the contract allow the MCO to offset overpayments only after you have been given notice of the alleged overpayment and an opportunity to appeal the overpayment determination? Is there a limit to how far back an MCO can correct overpayments (other than due to fraud)? Does the contract offer you a similar amount of time to correct underpayments?
- **Dispute Resolution.** Does the contract contain a streamlined process for claims/payment disputes? Does the contract provide a reasonable process for dispute resolution? Does the contract permit the provider to resort to more formal dispute resolution procedures without first exhausting the MCO’s appeal process?
CONTRACT REVIEW

- **Cost-Sharing.** Does the contract permit the provider to waive or reduce patient cost-sharing based on a determination of financial need?
- **Payment Terms.** Do the payment terms comply the reimbursement minimums set forth in the NYS BH RFQ? Are the payment terms for other products sufficient to cover your costs and consistent with prevailing rates?
- **All-Products.** Does the contract permit the provider to decide which of the MCO’s “products” to participate in both now and in the future? Is the provider notified in advance of a new product and rates and given the right to “opt-out”?
- **Regulatory Penalties.** Does the contract not include a provision allowing the MCO to allocate to the provider any portion of regulatory penalties imposed on it?
- **Termination.** Does the contract allow the breaching party to cure (fix) most breaches prior to termination? Does the contract permit the provider to terminate the contract for cause in the event of the MCO’s insolvency, bankruptcy or receivership?
- **Term.** Is the length of the term of the contract reasonable? If the contract includes an evergreen provision, is the amount of notice given to each party to terminate the contract reasonable?
- **Amendments.** Does the contract prohibit the MCO from amending the contract without the provider’s notice and assent? Does the contract permit the provider to propose amendments?
**Contract Review**

- **Insurance.** Does the contract require both parties to carry appropriate amounts of insurance coverage?

- **Indemnification.** Does the contract provide for mutual indemnification of any losses, claims or liabilities that result from each party’s willful and negligent conduct?

- **Access Standards.** Are you able to meet the access standards set forth in the contract? Does the contract permit you to make best efforts to meet those standards?

- **Notice.** Does the notice provision identify one or more individuals by name and title for official notices under the contract?

- **Licensure.** Does the contract only require you to report to the MCO final action taken by a state licensing board against a clinician (and not merely an investigation by a state licensing board)? Does a clinician's loss of licensure only result in termination of that specific clinician and not trigger rights to terminate the entire contract?

- **Credentialing.** Are the credentialing requirements and procedures clearly described in the MCO’s provider manual? If desired, does the contract permit the provider to enter a delegated credentialing agreement?

- **Utilization Management.** Does the MCO’s provider manual specify all services that will be subject to UM (including prior authorization, concurrent review, and other forms of coverage determinations)? Does the provider manual set forth the applicable standards of review?
Appendix B

Key RFQ Provisions
<table>
<thead>
<tr>
<th>Service Type</th>
<th>Emergency</th>
<th>Urgent</th>
<th>Non-urgent MH/SUD</th>
<th>BH Specialist</th>
<th>Follow-up to emergency or hospital discharge</th>
<th>Follow-up to jail/prison discharge</th>
</tr>
</thead>
<tbody>
<tr>
<td>MH Outpatient Clinic/PROS Clinic</td>
<td>Within 24 hrs</td>
<td>Within 1 wk</td>
<td></td>
<td></td>
<td>Within 5 days of request</td>
<td>Within 5 days of request</td>
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<tr>
<td>ACT</td>
<td>Within 24 hrs for AOT</td>
<td></td>
<td>n/a</td>
<td></td>
<td>Within 5 days of request</td>
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<tr>
<td>PROS</td>
<td>Timeframe to be determined</td>
<td>Within 2 wks</td>
<td></td>
<td></td>
<td>Within 5 days of request</td>
<td>Timeframe to be determined</td>
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<tr>
<td>Continuing Day Treatment</td>
<td></td>
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<td></td>
<td>2-4 wks</td>
<td>Timeframe to be determined</td>
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<tr>
<td>IPRT</td>
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<td></td>
<td></td>
<td>2-4 wks</td>
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<tr>
<td>Partial Hospitalization</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Within 5 days of request</td>
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<tr>
<td>Inpatient Psychiatric Services</td>
<td>Upon presentation</td>
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<tr>
<td>CPEP</td>
<td>Upon presentation</td>
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<tr>
<td>OASAS Outpatient Clinic</td>
<td></td>
<td>Within 24 hrs</td>
<td>Within 1 wk</td>
<td></td>
<td>Within 5 days of request</td>
<td>Timeframe to be determined</td>
</tr>
<tr>
<td>Detoxification</td>
<td>Upon presentation</td>
<td></td>
<td></td>
<td></td>
<td>Within 5 days of request</td>
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<tr>
<td>SUD Inpatient Rehab</td>
<td>Upon presentation</td>
<td></td>
<td>Within 24 hrs</td>
<td></td>
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<tr>
<td>Service Type</td>
<td>Non-urgent</td>
<td>BH</td>
<td>Follow-up to emergency or hospital</td>
<td>Follow-up to jail/prison discharge</td>
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<tr>
<td>Opioid Treatment Program</td>
<td>Within 24 hrs</td>
<td></td>
<td>Within 5 days of request</td>
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<tr>
<td>Rehabilitation services for residential SUD treatment supports</td>
<td></td>
<td>2-4 wks</td>
<td>Within 5 days of request</td>
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<tr>
<td>1915(i)-like Home and Community Based Services</td>
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<tr>
<td>Rehabilitation and Habilitation</td>
<td>n/a</td>
<td>n/a</td>
<td>Within 2 weeks of request</td>
<td>Within 5 days</td>
<td></td>
<td></td>
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<tr>
<td>Crisis Intervention/Respite</td>
<td>Immediately</td>
<td>Within 24 hours for short term respite</td>
<td>n/a</td>
<td>Immediate</td>
<td></td>
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<tr>
<td>Educational and Employment Support Services</td>
<td>n/a</td>
<td>n/a</td>
<td>Within 2 weeks of request</td>
<td>n/a</td>
<td></td>
<td></td>
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<tr>
<td>Peer Supports</td>
<td>n/a</td>
<td>Within 24 hours for symptom management</td>
<td>Within 1 week of request</td>
<td>Within 5 days</td>
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</tbody>
</table>
## NYS RFQ FOR BEHAVIORAL HEALTH BENEFIT

<table>
<thead>
<tr>
<th>Provider/Service Type</th>
<th>Contracting Requirement</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>OMH or OASAS licensed or certified providers</td>
<td>Any provider currently serving 5 or more Medicaid managed care enrollees for a minimum of 24 months; thereafter, higher of 50% of all licensed clinics or minimum of 2 per county</td>
<td>§ 3.6.A; § 3.5.F., Table 3</td>
</tr>
<tr>
<td>State operated outpatient programs</td>
<td>All</td>
<td>§ 3.6.B.</td>
</tr>
<tr>
<td>Opioid Treatment programs and Buprenorphine prescribers</td>
<td>All</td>
<td>§ 3.6.C.</td>
</tr>
<tr>
<td>OASAS residential programs</td>
<td>All</td>
<td>§3.6.D.</td>
</tr>
<tr>
<td>Crisis service providers for 24/7 coverage</td>
<td>All</td>
<td>§ 3.6.F.</td>
</tr>
<tr>
<td>PROS, IPRT, CDT, ACT, Partial Hosp., Inpatient Psych., HCBS, Psych. ERs, Detox</td>
<td>2 per urban county and 2 per rural region</td>
<td>§ 3.5.F., Table 3</td>
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<table>
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</thead>
<tbody>
<tr>
<td>OMH or OASAS licensed or certified providers</td>
<td>Must pay no less than Medicaid FFS rates for period of 24 months.</td>
<td>§ 3.7.B.iii.a.</td>
</tr>
<tr>
<td></td>
<td>Must guarantee payment at FFS rates for continuous ongoing episodes of care, up to 24 months, for medically necessary services provided to Plan regardless of their contract status.</td>
<td>§ 3.7.B.iii.b.</td>
</tr>
<tr>
<td>OASAS residential programs</td>
<td>Must pay allied clinical service providers on a single case or contracted basis</td>
<td>§ 3.6.D.</td>
</tr>
<tr>
<td>Clinics holding a state integrated license</td>
<td>Must contract for full range of services available under license</td>
<td>§ 3.6.G.</td>
</tr>
</tbody>
</table>
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<tr>
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<tbody>
<tr>
<td>Alternative Payment Methods</td>
<td>Plans and providers wishing to negotiate alternative payment methodologies for the first 24 months following implementation may do so pending State approval and subject to compliance with State and federal law.</td>
<td>§ 3.16.C.</td>
</tr>
<tr>
<td>Shared Savings</td>
<td>Subject to approval, Plans may enter into shared savings or incentive payment arrangements with providers to incentivize access to and coordination of care and to provide improved outcomes resulting from the integration of BH and PH services.</td>
<td>§ 3.16.D.</td>
</tr>
<tr>
<td>Topic</td>
<td>Requirement</td>
<td>Reference</td>
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</tbody>
</table>
| Incentive Payments| Financial incentives with providers must promote BH medical integration or behavioral health recovery outcomes by addressing performance including the following areas:  
   i. Submitting the screening results described Section 3.10 of the RFQ to the Plan.  
   ii. Developing care coordination capacity for members with co-occurring chronic medical conditions and BH disorders.  
   iii. Implementation of embedded / co-located primary care and Behavioral Health practitioners.  
   iv. Meeting the primary care needs of individuals with serious mental disorders.  
   v. Identification, referral, and treatment of individuals with FEP.  
   vi. Meeting specialized training or credentialing requirements.  
   vii. Consultation and referrals to specialty care settings (onsite consultations for rapid care).  
   viii. Increased employment or educational outcomes.  
   ix. Increased housing stability in integrated settings.  
   x. Reduction in incarceration rates.  
   xi. Reductions in smoking.                                                                                     | § 3.16.E. |
## NYS RFQ FOR BEHAVIORAL HEALTH BENEFIT

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</table>
| Credentialing of OMH and OASAS licensed or certified programs | License or certification must suffice for the Plan’s credentialing process.  
Plans are prohibited from separately credentialing individual staff members in their capacity as employees of these programs.  
Plans must contract for the full range of services offered under the programs’ license or certification. | § 3.7.H. |
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<tbody>
<tr>
<td>Utilization Review</td>
<td>Plans must use Medical Necessity Criteria (MNC) to determine appropriateness of new and ongoing services.</td>
<td>§ 3.9.A.</td>
</tr>
<tr>
<td>Prior Authorization and Concurrent Review Protocols</td>
<td>Prior authorization and concurrent review protocols must comport with NYS Medicaid medical necessity standards, federal and State parity requirements, and other related standards that may be developed by OASAS and OMH.</td>
<td>§ 3.9.B.</td>
</tr>
<tr>
<td>Level of Care</td>
<td>OASAS will identify the level of care guidelines that all plans must use for SUD services. The LOCADTR tool will be used for making prior authorization and continuing care decisions for all SUD services.</td>
<td>§ 3.9.E.ii</td>
</tr>
</tbody>
</table>
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</thead>
<tbody>
<tr>
<td>BH Admission and Continued Stay Authorization Decisions</td>
<td>Must be made by a BH professional (BHP) with a minimum of three years of clinical experience in a BH setting. A BHP is defined as an individual with an advanced degree in the mental health or addictions field who holds an active, unrestricted license to practice independently or an individual with an associate’s degree or higher in nursing who is a registered nurse with three years of experience in a mental health or addictions setting. The individual may meet the licensure requirement with an active, unrestricted license to practice independently or be a registered nurse in any state in the U.S.</td>
<td>§ 3.9.F.</td>
</tr>
<tr>
<td>Topic</td>
<td>Requirement</td>
<td>Reference</td>
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<tr>
<td>Prior Authorization, Concurrent or Retrospective Review Decisions</td>
<td>Plans must comply with NYS Medicaid guidance including managed care policy documents, relevant performance improvement specification documents or manuals and policies governing prior authorization, concurrent or retrospective review.</td>
<td>§ 3.9.L.</td>
</tr>
<tr>
<td>Topic</td>
<td>Requirement</td>
<td>Reference</td>
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<tr>
<td>Denials, Grievances &amp; Appeals</td>
<td>Must be peer-to-peer such that the credential of the licensed clinician denying the care must be at least equal to that of the recommending clinician for any denials. The reviewer should have clinical experience relevant to the denial (for example, a denial of rehabilitation services must be made by a clinician with experience providing such service or at least in consultation with such a clinician, and a denial of specialized care for a child cannot be made by a geriatric specialist).</td>
<td>§ 3.9.P.</td>
</tr>
<tr>
<td>Inpatient Level of Care Denials</td>
<td>A physician board certified in general psychiatry must review all inpatient level of care denials for psychiatric treatment. A physician certified in addiction treatment must review all inpatient level of care denials for SUD treatment.</td>
<td>§ 3.9.P.i-ii.</td>
</tr>
<tr>
<td>Topic</td>
<td>Requirement</td>
<td>Reference</td>
</tr>
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| Clinical Practice Guidelines | Plans must adopt, disseminate and implement State selected clinical practice guidelines listed below as well as nationally recognized clinical practice guidelines, including other evidence-based and promising practices:  
  a) SAMHSA’s ACT  
  b) SAMHSA’s Illness Management and Recovery  
  c) SAMHSA’s Integrated Dual Disorder Treatment for co-occurring disorders  
  d) SAMHSA’s Supported Employment (Individual Placement and Support)  
  e) SAMHSA’s Family Psychoeducation  
  f) Tobacco cessation  
  g) OMH FEP practice guidelines  
  h) Seeking Safety  
  i) Motivational Enhancement Therapy  
  j) Twelve-Step Facilitation  
  k) Cognitive Behavioral Therapy for SUD  
  l) Medication Assisted Recovery for SUD  
  m) Other SUD EBP as recognized by SAMHSA | § 3.10.K.vi |
## Clinical Quality Projects

**During 2015, MCOs will be required to design and implement a quality project to increase the screening and treatment for behavioral health conditions in primary care.**

1. Plans must implement a primary care screening and follow-up program for depression, anxiety disorders, and substance use disorders (including tobacco use) within one year after implementation and for the duration of the contract.

2. This program must include such follow-up methods as treatment in primary care for less complex conditions and referral to specialty care for complex cases, “collaborative care” and SBIRT.

3. The Plan must establish a process for screening individuals in high-risk medical populations for BH conditions and/or psychosocial stressors that may impact their medical condition or adherence to related treatment regimens. Unless the individual refuses such assistance, the Mainstream MCO shall ensure an assessment is completed to identify BH service needs and expedite referral to the appropriate services.

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<tr>
<th>Topic</th>
<th>Requirement</th>
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<tr>
<td>Clinical Quality Projects</td>
<td>During 2015, MCOs will be required to design and implement a quality project to increase the screening and treatment for behavioral health conditions in primary care.</td>
<td>§ 3.10.B.</td>
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<td>Behavioral and Medical Integration</td>
<td>The Plan must implement programs to manage complex and high-cost, co-occurring BH and medical conditions that include the following elements:</td>
<td>§ 3.10.C.ii.</td>
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<td>a) Identification processes, including claims-based analyses and predictive modeling, to identify high risk members;</td>
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<td>b) Stratification of cases according to risk, severity, co-morbidity, and level of need for targeted outreach;</td>
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<td>c) Outreach, engagement, and intervention strategies based on stratification (in partnership with health homes);</td>
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<td>d) Care coordination or linkage to Health Home care coordination as appropriate;</td>
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<td>e) Appropriate referral and use of community supports;</td>
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<td>f) Provider collaboration;</td>
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<td>g) Individualized, person-centered care plans; and</td>
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<td>h) Engagement monitoring, outcome monitoring and reporting at the individual, program and Health Home level.</td>
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## NYS RFQ FOR BEHAVIORAL HEALTH BENEFIT

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<td>Reduction of Emergency Department and Inpatient Admissions</td>
<td>Plans must analyze emergency department (ED) encounters and inpatient admission to identify inappropriate ED and inpatient use by BH recipients and develop and implement strategies to reduce inappropriate use of the ED and inpatient care.</td>
<td>§ 3.10.C.iii.</td>
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<td>Plan Performance Incentives</td>
<td>For Mainstream MCOs, there will be a greater emphasis on behavioral health performance metrics. An award may be bifurcated between physical health and behavioral health.</td>
<td>§ 3.17</td>
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<td>For HARPs, the quality incentive program will be financed using a premium withhold to create a pool for creating quality incentives.</td>
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<td>• Year 1: No withhold or quality incentive.</td>
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<td>• Year 2: Up to a 1.0% withhold to pay a quality incentive.</td>
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<td>• Year 3: Up to a 2.0% withhold to pay a quality incentive.</td>
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<td>• Year 4 and each year thereafter: 2.0% or greater.</td>
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CONTACT INFORMATION

Adam J. Falcone, JD, MPH
afalcone@FTLF.com

Feldesman Tucker Leifer Fidell LLP
1129 20th Street, N.W., Suite 401
Washington, DC 20036
(202) 466-8960