Section	Requirements Reference	BH MAP Requirement	Expected Readiness Evidence	Document(s) Submitted pg. number and highlight language where applicable
Personnel	Behavioral Health Guidance for Managed Care Organizations Carving Behavioral Health into Medicaid Advantage Plus Section 2.0	Compliance with BH Staffing Requirements for Medicaid Advantage Plus Plans.	MAP Plans with an affiliated Mainstream Medicaid Managed Care Plan (MMCP), Health and Recovery Plan (HARP) and/or HIV-Special Needs Plan (HIV-SNP) must attest the MMCP and/or HARP BH Key and Managerial Personnel will manage all MAP enrollee BH services. MAP Plans must submit a narrative describing how staff will cooperate across business lines to address MAP enrollee BH needs. If the MAP Plan intends to meet requirements in sections 2 and 3 of 2.0 Staffing in a different way than outlined above, the MAP Plan must provide a narrative describing their method of managing BH personnel.	
			MAP Plans without an affiliated MMCP, HARP or HIV-SNP, or those who are not using existing staff, with more than 4,000 HARP eligible enrollees must: i.Employ the following Personnel at a 1.0 FTE dedicated to MAP: a.BH Medical Director b.BH Clinical Director c.Manager(s) to fulfill BH Care Management (CM) and BH Utilization Management (UM) functions defined below in BH Personnel Requirements. ii.Submit BH Medical Director and BH Clinical Director résumés to ensure appropriate experience and license requirements are met as defined in the BH Staffing Requirements section of the Behavioral Health Guidance for Managed Care Organizations Carving Behavioral Health into Medicaid Advantage Plus document. MAP Plans without an affiliated MMCP, HARP or HIV-SNP, with fewer than 4,000 HARP eligible enrollees can either comply with 2.B. within the BH Staffing Requirements for Medicaid Advantage Plus Plans and submit requested information OR submit an alternate staffing plan detailing how the MAP Plan will address BH CM and UM requirements defined in the BH Staffing Requirements for Medicaid Advantage Plus Plans.	
			All MAP Plans must submit organizational chart(s) clearly outlining how BH staff will be integrated into existing organizational structures. All MAP Plans must explain how BH expertise[1] is incorporated into the Interdisciplinary Care Team to demonstrate coordination with physical health and long-term care management. [1]BH expertise must be provided by a BH Professional. BH Professional is defined on page 29 of the Adult BH RFQ.	
Personnel	Behavioral Health Guidance for Managed Care Organizations Carving Behavioral Health into Medicaid Advantage Plus Section 2.0	Regardless of how functions are assigned within the MAP Plan, all staff must be trained on the behavioral health requirements outlined in the BH Staffing Requirements for MAP.	MAP Plans must ensure staff are trained in accordance with the MAP Plan Staff Training Requirements listed in section 2.0 of Behavioral Health Guidance for Managed Care Organizations Carving Behavioral Health into Medicaid Advantage Plus. MAP Plans without an affiliated mainstream/HARP: Complete MAP Exhibit 1: Training Module Requirements. MAP Plans with affiliated mainstream/HARP: MAP Exhibit 1 does not need to be completed if utilizing existing mainstream/HARP staff who have already undergone training on behavioral health as outlined in the requirements. Must note this in the documents submitted column.	
Member Services	Adult BH RFQ Section 3.4	Member Services requirements for the Plan as delineated in the Adult RFQ (https://omh.ny.gov/omhweb/bho/rest-of-state-final-rfq.pdf).	MAP Plans without an affiliated mainstream/HARP: Submit Member Services P&Ps with completed checklist (MAP Exhibit 2). MAP Plans with an affiliated mainstream/HARP: Submit Member Services P&Ps with completed checklist (MAP Exhibit 2) if utilizing different member services staff for MAP product line. If utilizing existing member services staff, plan must note this in the documents submitted column and attest existing P&Ps remain in compliance, unless otherwise updated.	
Network	Behavioral Health Guidance for Managed Care Organizations Carving Behavioral Health into Medicaid Advantage Plus Section 1.0	Compliance with BH Network Requirements for Medicaid Advantage Plus Plans	1. MAP Plans will sign the BH MAP Requirements Attestation for complying with BH MAP network requirements 2. Submit monthly network report to PNDS and complete the Exhibit C:Mobile Crisis Services Contracting Status Report Workbook (to be provided by the State) for the State to monitor progress with network development. The Plan must note in the documents submitted column when first network report is submitted to PNDS.	
Network	Behavioral Health Guidance for Managed Care Organizations Carving Behavioral Health into Medicaid Advantage Plus Section 1.0	Plans shall update and maintain the Plan's provider manual to include all relevant information on BH services and BH-specific provider requirements as applicable to the MAP product line.	New York State will provide guidance at a later date. No submission required at this time.	
Network	Behavioral Health Guidance for Managed Care Organizations Carving Behavioral Health into Medicaid Advantage Plus Section 1.0	Plans will conduct provider training for newly contracted behavioral health providers to ensure they have appropriate knowledge, skills, and expertise and receive technical assistance to comply with the requirements under managed care. This includes, but is not limited to training on: a.Billing (including claims testing), coding, data interfaces and claiming resources/contacts, in alignment with the NYS Medicaid Advantage Plus Plans Behavioral Health Billing and Coding Manual. b.UM requirements and documentation requirements. c.Evidence-based/promising practices and recovery principles	All MAP plans will sign the BH MAP Requirements Attestation for complying with BH MAP network training requirements. In addition: MAP Plans without an affiliated mainstream/HARP: MCOs with a MAP-only product line must provide a narrative describing training that will be offered to newly contracted BH providers.	

Care Coordination	Behavioral Health Guidance for Managed Care Organizations Carving Behavioral Health into Medicaid Advantage Plus Section 3.0	Compliance with BH Care Coordination Requirements for Medicaid Advantage Plus Plans	All MAP Plans will sign the BH MAP Requirements Attestation for complying with BH Care Coordination Requirements.	
UM	Adult BH RFQ Section 3.9 A-P	Requirements as delineated in the RFQ 3.9. A-P with the following exceptions: i.Section 3.9 B: The Table 1 referenced in 3.9 B is outdated. Please refer to the Utilization Management section of the *Adult Behavioral Health Managed Care Policy, Guidance, and Resources* webpage and the *Medicaid Managed Care Crisis Intervention* webpage for the list of BH services covered by MAP plans. ii.Section 3.9 O: The Section 3.3 requirements referenced in 3.9 O do not apply to MAP Plans. This is superseded by the MAP BH Staffing Requirements Adult Behavioral Health Managed Care Policy, Guidance, and Resources web link: https://omh.ny.gov/omhweb/bho/policy-guidance.html Medicaid Managed Care Crisis Intervention web link: https://omh.ny.gov/omhweb/bho/crisis-intervention.html	MAP Plans without an affiliated Mainstream and HARP must provide Utilization Management P&Ps with completed checklist (MAP Exhibit 3). MAP Plans with an affiliated Mainstream and HARP do not need submit materials, however must indicate in the documents submitted column approved P&Ps remain in compliance, unless otherwise updated.	
UM	Adult BH RFQ Section 3.9	The Plan shall develop and implement BH-specific UM protocols, including policies and procedures (P&Ps) and level of care guidelines that comply with state and federal parity requirements. SUD: ii. The Plan's practices and approaches to utilization review must align with state and federal laws related to utilization review and behavioral health parity. OASAS will identify the level of care guidelines that all Plans must use for SUD services. The LOCADTR 3.0 tool will be used for making prior authorization and continuing care decisions for all SUD services. MH: The Plan's practices and approaches to utilization review must align with the OMH Guiding Principles (https://omh.ny.gov/omhweb/bho/omh_mnc_guiding_principles.pdf) as well as state and federal laws related to utilization review and behavioral health parity. In line with parity efforts by OMH, the Plan must either: Notify OMH that they will adopt the Best Practices for Utilization Review (https://omh.ny.gov/omhweb/bho/docs/best-practices-manual-utilization-review-adult-and-child-mh-services.pdf) and also adopt the Level of Care Utilization System for Psychiatric and Addiction Services (LOCUS) and Child and Adolescent Level of Care Utilization System (CALOCUS) to support level of care determinations for mental health services for adults and children, respectively. OR: Request approval to use a level of care determination tool other than the LOCUS/CALOCUS and/or approaches different from those outlined in the manual. Plans that choose this option must also submit documentation (clinical review criteria, policies and procedures, and comparative analyses of clinical review criteria and policies and procedures, etc.) demonstrating that their utilization review approach is comparable to and no more restrictive than the Plan's medical management approaches to treatments for medical and surgical conditions.	MAP Plans without an affiliated mainstream/HARP: Describe how the LOCADTR tool will be implemented to make LOC/medical necessity determinations for SUD services, including the training of UM and clinical management staff. Describe quality assurance process used to assess compliance with level of care/medical necessity determination requirements for SUD services. The Plan must submit LOCs for ACT and PROS that are affiliated with guidance issued by OMH. For all other MH services, depending on option that Plan chooses: Option 1 - The Plan must submit a notification that they will adopt the Best Practices UM Manual and LOCUS/CALOCUS. OR Option 2 - The Plan must submit Clinical review criteria, policies and procedures, and comparative analyses of clinical review criteria and policies and procedures, etc. must demonstrate that Plan's utilization review approach is comparable to and no more restrictive than the Plan's medical management approaches to treatments for medical and surgical conditions. MAP Plans with an affiliated mainstream/HARP: Plans with an affiliated HARP/Mainstream product line that have already submitted Medical Necessity Criteria and associated policies and procedures must re-submit being sure to specify the exact plan name and product lines that the materials apply to, along with any differences and/or updates to previously submitted documents.	
Clinical Management	Behavioral Health Guidance for Managed Care Organizations Carving Behavioral Health into Medicaid Advantage Plus Section 3.0.	F.Develop and implement a system to enable UM/CM staff to identify high-risk members. UM/CM staff must address high-risk member BH and social determinants of health needs through care coordination. 1.At minimum, the system should include the following criteria to identify high-risk members: i.Enrollees meeting HARP target criteria and risk factors identified by an RRE code ii.Enrollees with a current or expired (within the prior five years) AOT order iii.Discharge from a State Psychiatric Hospital, State Community Residence, or Adult Home iv.New onset psychosis v.Homelessness vi.Homebound vii.Frequent psychiatric inpatient or detox usage viii.Discharge from psychiatric inpatient unit at a general hospital ix.Discharge from an emergency department for a BH-related condition x.Use of a BH crisis service xi.History of suicide attempt xii.Other criteria determined to indicate high risk	MAP Plans must provide a narrative describing how they will meet the requirements as outlined in column C. In addition, submit a P&P for UM/CM staff describing how they will address high-risk member BH and social determinants of health needs through care coordination.	
Clinical Management	Adult BH RFQ Section 3.10	Describe the Plan's strategy to ensure the pharmacy management program requirements indicated in Section 3.10F (Clinical Management) are met. Plans should have specific policies and procedures for identifying and addressing pharmacotherapy quality of care issues. At a minimum procedures should include but not be limited to: a. Poly-pharmacy and inappropriate indications specifically around metabolic and cardiovascular side effects of psychotropic medications, and should include guidance for Plan staff regarding case and provider-specific interventions; b. Medication side effects, especially in the areas of metabolic and weight gain. Procedures must address: i. How this will be monitored; ii. How communication will occur with physical health providers; and c. What network services will be in place around patient education and service plan development to offset these potential life threatening side effects.	MAP Plans without an affiliated Mainstream and HARP must provide a narrative which describes the Plan's strategy to ensure the pharmacy management program complies with Adult BH RFQ Section 3.10F. MAP Plans with an affiliated Mainstream and HARP do not need submit materials, however must indicate in the documents submitted column approved P&Ps remain in compliance, unless otherwise updated.	
Clinical Management	Adult BH RFQ OMH AOT Guidance: Using PSYCKES to identifymembers with Assisted Outpatient Treatment (AOT) orders and/or who receive Assertive Community Treatment (ACT) services	Assisted Outpatient Treatment Requirements: a. There is coordination with the assisted outpatient treatment case manager to address any barriers to the treatment plan. b. That members with an AOT court order are assigned to the proper LOC management. c. AOT orders are appropriately tracked in the Plan's electronic record such that AOT status is immediately available to all Plan care management and utilization management staff. AOT Guidance Web Link: Using PSYCKES to identify members with Assisted Outpatient Treatment (AOT) orders and/or who receive Assertive Community Treatment (ACT) services- https://omh.ny.gov/omhweb/bho/policy-guidance/psyckes_aot_act.pdf	MAP Plans without an affiliated Mainstream and HARP must provide documentation that describes process to ensure enrollees with AOT court orders are easily identified in the Plan's electronic record by Utilization Management and Care Management staff. Plans must submit evidence of care coordination with AOT court ordered service providers. MAP Plans with an affiliated Mainstream and HARP do not need submit materials, however must indicate in the documents submitted column approved P&Ps remain in compliance, unless otherwise updated.	

Clinical Management	Adult BH RFQ Section 3.10 G	The Plan shall develop definitive strategies to promote Behavioral Health (BH) and Physical Health (PH) medical integration. Considerations include: - i - ii. Co-location of BH practitioners in primary care settings and/or co-location of PCPs in BH settings; - iii. The availability of a PCP to provide consultation on complex health issues with the psychiatrist, nurse practitioner, and/or nurse care manager; - iv. The availability of a psychiatrist to provide consultation on complex behavioral health issues with PCPs, nurse practitioner, and/or nurse care manager; - v. Plan referral of individuals with high PH/ BH needs to clinics with a State integrated delivery license where available. The Plan will institute monitoring mechanisms to measure the effectiveness of its strategy.	MAP Plans without an affiliated Mainstream and HARP must provide must provide a narrative on how they will meet the expectations in column C. MAP Plans with an affiliated Mainstream and HARP do not need submit materials, however must indicate in the documents submitted column approved P&Ps remain in compliance, unless otherwise updated.	
Clinical Management	Behavioral Health Guidance for Managed Care Organizations Carving Behavioral Health into Medicaid Advantage Plus Section 3.0	The MAP Plan will integrate behavioral health (BH) services and BH considerations into the existing MAP Plan care management structure. This must encompass requirements D. 1-8 from the Care Coordination Requirements section of the BH Guidance document.	MAP Plans must attest to comply with the requirements listed in the Behavioral Health Guidance for Managed Care Organizations Carving Behavioral Health into Medicaid Advantage Plus, inclusive of all care coordination requirements.	
QM & Reporting	Adult BH RFQ Section 3.12	Requirements as delineated in the Adult RFQ for amending its quality assurance program. A separate BH QM and UM committee is not required however the MAP plan must ensure their exiting QM and UM committees review the behavioral health criteria outlined in section 3.12.	All MAP Plans must submit a narrative explaining how they will include the BH requirements for QM and UM into their existing committee structure and what behavioral health personnel will attend these committees.	
Claims/IT	New York State Medicaid Advantage Plus Plans Behavioral Health Billing and Coding Manual to be released	Requirements as delineated in the New York State Medicaid Advantage Plus Plans Behavioral Health Billing and Coding Manual.	Pending release of New York State Medicaid Advantage Plus Plans Behavioral Health Billing and Coding Manual, MAP Plans will sign an attestation to confirm systems configurations are complete and incompliance with requirements. The State reserves the right to request screenshots or P&Ps for the purposes of verifying compliance.	

MAP Staff Training Requirements

Training Topic	Clinical Staff	Member Services	Provider Relations
New York State's vision, mission, goals, operating principles for behavioral health (BH)	☑	☑	☑
BH services and Home- and Community-Based Services (HCBS)	☑	☑	☑
Health and Recovery Plan and HCBS eligibility requirements and protocols	☑	☑	☑
Services for individuals with first episode psychosis	☑	☑	
Evidence-based practices	☑		☑
Recovery principles	☑		☑
BH/medical integration; co-occurring BH and medical disorders; integrated care management principles.	☑	☑	☑
Level of care guidelines for new BH services	☑		
Access standards for new BH services	☑	☑	☑
New authorization requirements for BH	☑	☑	☑
After hours and crisis triage protocols	☑	☑	☑
Linkage requirements(i.e., with social services, Office for People With Developmental Disabilities, non-Medicaid BH services)	☑	☑	☑
Cross training for specialty behavioral health, physical health and long-term care in treatment approaches and illness progression to ensure training outside their specialties	☑		

MAP Exhibit 1: Training Module Requirements						
Training Module Topic	**Target Audience**	**Summary of Content/Learning Objectives** This should demonstrate the training is tailored to the particular audience.	**Mode of Delivery** Indicate if training is conducted live (in-person and/or via web-ex), recorded, or is self-directed.	**Competency Assessment** Indicate if there is a pre-test, post-test, both, or neither.	**Duration of Training** (i.e., 30, 60, 90 or 120 minutes)	**Trainer Name and Qualifications**
New York State's vision, mission, goals, operating principles for behavioral health (BH)	Clinical Staff					
	Member Services					
	Provider Relations					
BH services	Clinical Staff					
	Member Services					
	Provider Relations					
BH service eligibility requirements and protocols	Clinical Staff					
	Member Services					
	Provider Relations					
Services for individuals with first episode psychosis	Clinical Staff					
	Member Services					
	Provider Relations	NA	NA	NA	NA	NA
Evidence-based practices	Clinical Staff					
	Member Services	NA	NA	NA	NA	NA
	Provider Relations					
Recovery principles	Clinical Staff					
	Member Services	NA	NA	NA	NA	NA
	Provider Relations					
BH/medical integration; co-occurring BH and medical disorders; integrated care management principles.	Clinical Staff					
	Member Services					
	Provider Relations					
Authorization requirements for BH and level of care guidelines for new BH services	Clinical Staff					
	Member Services	NA	NA	NA	NA	NA
	Provider Relations	NA	NA	NA	NA	NA
Network and access standards for new BH services	Clinical Staff					
	Member Services					
	Provider Relations					
After hours and crisis triage protocols	Clinical Staff					
	Member Services					
	Provider Relations					
Linkage requirements(i.e., with social services, Office for People With Developmental Disabilities, non-Medicaid BH services)	Clinical Staff					
	Member Services					
	Provider Relations					
Cross training for specialty behavioral health, physical health and long-term care in treatment approaches and illness progression to ensure training outside their specialties	Clinical Staff					
	Member Services	NA	NA	NA	NA	NA
	Provider Relations	NA	NA	NA	NA	NA

MAP Exhibit 2: Member Services P&P Checklist

Instructions:
Complete the checklist with the operational Policy Name and relevant page number(s). Do not modify this file by adding or deleting columns or changing header names in row 3 or 4.

NOTE: Plans must highlight within submitted documents specific language pertaining to standards reflected below. Incomplete or inaccurate checklists will be sent back for resubmission.

			NYS Reviewer Use Only	
Adult BH RFQ Reference	**Item**	**P&P Name and Page Number Reference(s)**	**Met Standard (Yes/No)**	**Comments**
3.1.I.i 3.1.I.ii 3.4.A.	Information and referral (including crisis referral) on BH benefits and services available: - 24/7/365 via live answer toll-free line. - during business hours (8 am to 6 pm) in NYS service center unless pre-approved by NYS to operate out-of-state.			
3.1.I.ii	Protocols for linkage between the crisis line and local crisis responders.			
3.4.C.iv.	Member service staff have access to appropriately qualified clinicians to assist with triaging callers who may be in crisis. Telephone crisis triage protocols should identify: - Timely access to qualified clinicians to assist with triaging callers who may be in crisis. - How a warm transfer is conducted without putting the member on hold. - How member services staff are trained to identify a caller who may be in crisis. - The process to follow-up with a member after the crisis. - The process to follow-up with a member if 911 is called.			
3.4.C.i.	Information on the expanded array of Medicaid BH benefits and services including where and how to access them.			
3.4.C.ii.	BH service prior approval requirements.			
3.4.C.iii.	Requirements for responding promptly to family members and for supporting linkages to other service systems including, but not limited to: OASAS, OPWDD, and State or federally funded non-Medicaid BH services, NYS Justice Center, law enforcement, and the criminal justice system.			

MAP Exhibit 3: UM P&P Checklist

Instructions:

Complete the checklist with the operational Policy Name and relevant page number(s). Do not modify this file by adding or deleting columns or changing header names in row 3 or 4.

NOTE: Plans must highlight within submitted documents specific language pertaining to standards reflected below. Incomplete or inaccurate checklists will be sent back for resubmission.

			NYS Reviewer Use Only	
Adult BH RFQ Reference	**Item**	**P&P Name and Page Number Reference(s)**	**Standard Met (Yes/No)**	**Comments**
3.9.G	Procedures to communicate with/educate provider about the Plan's UM protocols and level of care guidelines.			
3.9.I	Requirements for the performance of inter-rater reliability (IRR) testing of clinical review criteria at least annually and which require a minimum pass rate of 85 percent. Policies shall provide for the remediation of poor IRR results and IRR testing for all new staff before they can conduct utilization review without supervision.			
3.9.A	When a member is ready for discharge, how UMs/CMs work with providers to identify an appropriate new level of care, make necessary referrals, and transition the member without disruption in care.			
3.9.E.iv	How UMs/CMs promote quality of care and adherence to standards of care through active care management to shape providers.			
3.9.K.i-vi	Protocols for UMs/CMs to address discharge planning.			
3.9.F;	Confirmation that all BH admission and continued stay authorization decisions are made by a U.S. BHP with a minimum of three years of clinical experience in a BH setting.			
3.9.O-P	Confirmation that: - All decision makers have clinical expertise in treating the member's condition, stratified by age - Denials, grievances, and appeals are peer-to-peer (i.e., the credential of the licensed clinician denying the care is at least equal to that of the recommending clinician). - A physician board certified in general psychiatry reviews all denials for inpatient psychiatric treatment. - A physician certified in addiction treatment reviews all denials for inpatient SUD treatment.			
3.1.G.vi	Protocols to ensure BH utilization review is available 24/7/365 including access to: - Appropriate clinical personnel to conduct PA (BHP with 3 years BH experience). - Staff knowledgeable about the BH benefit, the NYS managed care rules, the BH UM criteria - Staff able to response to post-stabilization PA requests within 1 hour.			