

**Questions and Answers for
Utilization, Quality and AIMS Reviews, RFP # 0712071036**

GENERAL SUBMISSION REQUIREMENTS

1. Can bidders submit proposals for just one part, or are we required to respond to both Part A and Part B? (RFP pg. 10)
Proposals may be submitted for Part A or Part B or both. If a bidder is submitting Proposals for both, they must submit the Part A and Part B Proposals separately.

2. Should the proposal contain two (2) CD ROMs, one for the Technical Proposal and one for the Cost Proposal? (RFP pg. 46)
Yes, the Technical Proposal package should contain one (1) CD ROM with the Technical Proposal on it and the Cost Proposal package should contain one (1) CD ROM with the Cost Proposal on it.

3. Can cost/benefit ratios from prior experience, which along with gross cost savings indirectly reveal pricing information, be included in the Technical Proposal? (RFP pg.38)
Cost information should not appear in the Technical Proposal.

4. Please explain the payment methodology for this contract. (RFP pg.198)
Payment will be based on the proportion of deliverables that are completed at each payment period.

5. Will a DEAA (Data Exchange Application and Agreement) be required before work can begin on the project?
Yes, in order to access Medicaid client data a Data Exchange Application and Agreement will be required.

6. If only one year's price is submitted, how will the total contract bid price be calculated?
The bidder is expected to submit an annual fixed price proposal. This will be multiplied by five and start-up fees will be added to determine the final bid.

7. Can a list of the attendees to the Bidders' Conference be made available?
The following organizations were represented at the Bidders' Conference:

*Dakota Consulting
First Health Services Corporation
IPRO
KePRO
Louisiana Health Care Review
Maximus
New York County Health Services Review Organization
Permedion of Health Management Systems
US Preventive Medicine, Inc.*

8. Can the Bid Form be made available in Word format?
Yes, the Bid Form and other forms to be submitted will be made available in Word format and will be posted on the DOH website.

9. The UR/QI RFP includes the Medicaid Confidential Data/Protected Health Information Privacy Language (Attachment 20), but does not include this on the Proposal Submission checklist. This is a required form for the AIMS proposal submission. Please confirm whether this form (signed) is a required form for proposal submission for the UR/QI proposal.
The Medicaid Confidential Data/Protected Health Information Privacy Language (Attachment 20) is a document that will be part of the successful bidders' contract with the NYSDOH. This signed form should be included in the Technical Proposal for both Part A and for Part B. See Amendments for a revised list of required forms for the Technical Proposal for Part A.

10. UR/QI Technical Proposal Form 1 and Form 2 call for the entry at the top of "Contract Year" - Is the requirement to submit the forms for the first year of the contract or to submit five forms each, one for each year of the contract? Form 3 calls for the entry at the top of "Contract Period" - is this a different time period than for Form 1 and Form 2?
On Technical Proposal Form 1 and 2 the term "Contract Period" should replace "Contract Year". Submit only one of each form to reflect staff to be used throughout the five year contract period. Form 3 is not a different time period. These forms have been revised accordingly and are available in Word format on the website.

11. Attachment 3 (Bid Form), item A, requires the entry of “total price” – is this amount the total price for the five year period of the contract or the first year amount?

The total price is the price for the five year period of the contract plus start-up costs.

12. The Proposal Checklist in the UR/QI RFP lists NYS Taxation and Finance Form (ST-220-CA) - RFP Attachment 10, but does not list NYS Taxation and Finance Form (ST-220-TD) - RFP Attachment 9. Is Attachment 9 a required form for submission?

Attachment 9 – NYS Taxation and Finance Form (ST-220-TD) is submitted to the New York State Department of Taxation and Finance and will be included in the successful bidder’s contract with the NYSDOH. This form should be included in the Technical Proposal for both Part A and for Part B. See Amendments for a revised list of required forms for the Technical Proposal for Part A and Part B.

**PART A:
MEDICAID UTILIZATION REVIEW AND QUALITY IMPROVEMENT ACTIVITIES**

Quality Improvement Projects (QIP)

13. What were the projects for the past 5 years and the categories of Quality Improvement Projects by the year? (RFP pg. 15)
Over the past 5 years the current contractor has conducted two annual quality improvement projects focused on asthma and diabetes.

14. What has been the volume of Quality Improvement Project reviews over the past five years per year? (RFP pg. 32)
The average annual number of participating QIP sites over the past 5 years has been 25. Of those 25 sites, there is a blend of diabetes and asthma focused projects. Baseline chart abstraction has been roughly 150 reviews per site (per disease). Subsequent year chart abstraction has been roughly 50 reviews per site (per disease). Currently, there are a total of 33 participating QIP sites, of which 23 are focused on asthma and 25 are diabetes.

15. Are the "75 medical records at each clinical site for a total of 2,250 reviews" inclusive of both QIPs, or are there 2,250 reviews for each QIP? (RFP pgs. 32)
The initial contract year at each QIP site will include an annual medical record chart abstraction review of at least 75 reviews per medical condition. For example, if a single site participates in both QIPs, that site would have 150 reviews done in the first year. Subsequent year(s) medical reviews will include a minimum of 30 annual reviews per site/per medical condition. At the discretion of the Department, these requirements are subject to change.

To assure consistency in the preparation of the Technical and Cost Proposals, it is requested that the bidder base its QIP projections on review of 75 medical records at each clinic site for a total of 2,250 reviews (75 reviews x 30 sites). These projections are not binding and are subject to change based on needs of this contract.

16. What clinical criteria are currently used for these projects? (RFP pg. 17)
National evidenced-based treatment guidelines are used for the QIPs. The asthma QIP utilizes the Expert Panel Report 3 (EPR-3): Guidelines for the

Diagnosis and Management of Asthma (The National Heart, Lung, and Blood Institute) and the diabetes QIP utilizes the American Diabetes Association's "Standards of Medical Care in Diabetes".

17. Has the existing contractor been using the "Chronic Care Model", and if so, for how long? Will the new contractor be expected to continue the programs begun by the existing contractor? (RFP pg.15)

For the past 7 years and currently, the QIPs have been based on the tenets of the "Chronic Care Model". It is expected that the UR/QI agent will select a minimum of six QIP sites annually, chosen in cooperation with Department personnel. The UR/QI agent will conduct continuous recruitment of QIP sites in order to engage a minimum of 30 QIP statewide sites over the duration of the five year contract. Current QIP sites will be evaluated at the beginning of the new contract period and their continuation status will be determined at that time.

18. Has the existing contractor already developed QIP sites for Asthma and Diabetes, and if so, will the Department indicate which these are? Will the new contractor be expected to continue these programs? (RFP pg.15)

There are a total of 33 participating QIP sites; of which 23 are focused on asthma and 25 are diabetes. The status of these programs will be determined at the beginning of the new contract period.

Participating sites include:

Boriken Neighborhood Health Center

Castle Hill Family Practice

Dolan Family Health Center

Dolan Family Health Center Pediatric Clinic

Elmont Community Health Center

Fordham Family Practice

Freeport – Roosevelt Community Health Center

Goldman Family Med Center - General Medical Clinic - adult medicine

Hempstead Community Health Center

Inwood- Lawrence Community Health Center

Long Beach Medical Clinic

Nassau University Medical Center Diabetes Clinic

Nassau University Medical Center Omni Medical Clinic FAMILY PRACTICE

Nassau University Medical Center Omni Medical Clinic INTERNAL MEDICINE

North General Hospital Diagnostic and Treatment Center General Medical Clinic

North General Hospital Diagnostic and Treatment Center General Pediatric Clinic

North General Hospital Diagnostic and Treatment Center Pediatric Asthma Clinic

North Shore/LIJ health System- Gen Medical Clinic

North Shore/LIJ Health System-Schneider Children's Hosp-Division of General Pediatrics

Phillips Ambulatory Care Center-Pediatrics Associates

Settlement Health & Medical Services
St. Peter's Family Health Center-General Medicine
St. Peter's Family Health Center-Pediatrics
St. Peter's Rensselaer Health Center
St. Peter's Slingerlands Health Center Pediatrics
Staten Island University Hospital-Bay St.General Medicine
Staten Island University Hospital-General Medicine
Staten Island University Hospital-Pediatrics
Staten Island University Hospital-South General Medicine
West Farms Family Practice
Westbury- New Cassel Community Health Center
Whitney M. Young, Jr. Health Center, Inc.
Williamsbridge Family Practice

19. Please explain the role of the Institute for Healthcare Communications (IHC) in the Decision Support component of QIPs. (RFP pg.16)

The Institute for Healthcare Communications (IHC) "Motivational Interviewing" curriculum is being conducted at QIP sites by the current contractor.

20. Does the Department have a desired format for the Peer Comparison Reports? Can the Department provide an example of one? (RFP pg.17)

The Department is seeking new ideas and strategies that will assist providers in identifying ways to achieve improved process and patient outcomes and the 'Peer Comparison' report is one of many interventions to achieve these goals. We are looking for bidders to submit examples of reports that support these goals.

21. Can the Department provide an example of a current "disease focused" toolkit that the contractor would be expected to reinforce? (RFP pg.18)

An example of a "disease focused" toolkit can be found on the Department's website; the "Diabetes Prevention and Management Toolkit";
<http://www.health.state.ny.us/diseases/conditions/diabetes/adult_tool_kit.htm>

22. Section III.D. (page 15) of the RFP states "...UR/QI agent will conduct continuous recruitment of QIP sites in order to engage a minimum of 30 QIP statewide sites over the duration of the five year contract." Since an individual site can participate in one or both projects, if each site participates in both projects, then there would be only 15 QIP practice sites over the five-year contract period. Please confirm that this understanding is correct, i.e., there could be as few as 15 sites over the five year period of the contract based on the RFP requirements.

If each QIP site participates in two projects (for example, they participate in both the asthma and diabetes QIP), then there could be a minimum of 15 total practice sites over the five year contract period.

23. Cost Proposal Form 1.2 states "Include a work plan & schedule of deliverables for each QIP". Should the two work plans and schedule of deliverables be included with the Cost proposal or the Technical proposal?

Each QIP should include a work plan and deliverable schedule, void of cost information, in the Technical proposal. QIP work plans and deliverable schedules are not required in the cost proposal; disregard this requirement that is listed on 'Cost Proposal Form 1.2- Quality Improvement Projects. Cost Proposal Form 1.2 has been revised to reflect this answer and is available on the website in Word format.

MEDICAID UTILIZATION REVIEW AND QUALITY IMPROVEMENT

24. Can the State provide the term and dollar value of the current contract? (RFP pg. 11)

The contract term is 4/1/06 to 3/31/08 for \$23,310,000. There is an amendment in process increasing the funding by approximately \$2 million, but this has not yet been approved by the Office of the State Comptroller (OSC).

25. What was the past 5 year volume and the categories of quality of care concern deficiencies and adverse patient outcomes by the year? (RFP pg. 14)

We are reluctant to go back 5 years, since there have been so many significant changes to the Medicaid program, managed care enrollment, new priorities, etc. Below are the requested volumes for 4/1/05 to 9/30/07. This data is not available by category of concern.

Period: Volume:

4/1/07 – 9/30/07 = 234

4/1/06 – 3/31/07 = 858

4/1/05 – 3/31/06 = 809

26. What are the current criteria used for each of the aspects of appropriate care and cost effectiveness? (RFP pgs. 19 – 20)

InterQual, DOH psychiatric criteria, state provided detox criteria, and federal rehab criteria are currently in use. Cost effectiveness is the ratio of expenditures to savings.

27. Can the Department provide its inpatient psychiatric care criteria? (RFP pg. 35)

Yes, the criteria can be found in an attachment at the end of the Questions and Answers.

28. In the list of Utilization Review Responsibilities, what is meant by 'Other reviews required by the Department': what were the reviews, their volumes over the past 5 years (volume by the year)? (RFP pg. 21)

The bid is to be based on workload data, included in the RFP. We have attempted to categorize all anticipated work into categories. We understand that things change so that is why we added the "unanticipated work" section. Below is a list of many of the "other reviews" going back to 2005. As indicated, we are reluctant to go back further given all the changes which have taken place.

Topic	Approximate Volume/Cases
<i>Childhood Immunization</i>	<i>370</i>
<i>QIP Pneumonia</i>	<i>1150</i>
<i>Follow-up to Adult Bariatric Surgery</i>	<i>270</i>
<i>Potential Preventable Complications</i>	<i>1200</i>
<i>Review of OSC Referrals</i>	<i>N/A</i>
<i>Recurrent Admission Study</i>	<i>N/A Data Study</i>
<i>Critical Care Hospital Study</i>	<i>72</i>

29. What software is being used to conduct DRG Validation reviews and what is the length of time to complete a review? (RFP pg. 21)
AHA coding clinic and the 3 M grouper. The time varies based on the complexity of the case.

30. What is the volume of Cost Outlier reviews over that last 5 years by year? (RFP pg. 23)
A cost outlier is generally a case that is billed at more than two times the DRG payment. The volume has fluctuated around 2,500 per year, but bids should be based on workload projections in the RFP.

31. What is the volume of Consultant Reviews over the last 5 years by year and the length of time to complete a review? (RFP pg. 23)
This has varied from between 250 to 400 per year, but the bid should be based on workload projections in the RFP.

32. What is the volume of D & T Center reviews over the last 5 years by year and the length of time to complete a review? (RFP pg. 23)
We have been doing less than 18 per year (approximately 15 last year), but the bid is to be based on the projection of 18 audits as set forth in the RFP. We use professional judgment in completing these reviews, but in general we are looking to see if services are provided on days billed to Medicaid.

33. Are the current staff training plans used by the current vendor available? (RFP pg. 27)
This is not available, and would require a FOIL request. The requirements for staff training are those stated in the RFP.

34. For the following review types: Random/Focused Review, Specialist Consultant Reviews, Additional NYPORTS Review, and Additional Quality of Care Reviews; what is the current volume of each review type over the past 5 years (per year)? (RFP pg. 29)

We are reluctant to go back 5 years since there have been so many significant changes with Medicaid Managed Care enrollment, a move to outpatient care, new priorities etc. so that past volumes may not be reflective of future plans as set forth in the RFP. We do not want to provide data which could then be misunderstood and result in confusion regarding the Bid preparation. The workload projections are our best estimate of what the Medicaid Program will experience going forward. In addition, we have included "unanticipated work" to cover unexpected occurrences. We have carefully defined what counts as a case and what goes into each type of review. i.e. DRG review, NYPORTS etc. These specifications impact case counts and volume. However, volumes over the past 2 years are often related to the workload projection. These projections reflect new priorities, other findings, and potential changes to the Medicaid program.

Review types:

Random/Focused -These are generally random reviews, approximately 5,000 per year, but they could be directed at hospitals and/or providers with questionable review findings

Special Consultant Reviews – These range from 250 – 400 per year and could fall under any medical specialty or topic i.e. Cardiac Care, Mental Health issues, Transplants, etc.

Additional NYPORTS Reviews - This is a new category.

Additional Quality of Care Review – This is a new category, but in the past when other reviews were conducted the topics have included:

Childhood Immunization

QIP Pneumonia

Follow-up to Adult Bariatric Surgery

Potential Preventable Complications

Review of OSC Referrals

Recurrent Admission Study

Critical Care Hospital Study

35. The "capability to void and adjust improper hospital claims" - can this be clarified to provide information on what the system is and where the hospital claims are processed (NY DOH, eMedNY or other contractor) and if the transaction can be directly updated, electronic transaction and/or via a hardcopy notice/letter - or is

the choice of update methods more limited [ie. only direct web update appropriate]? (RFP pg. 34 – Data Requirements)

Medicaid hospital voids and adjustments are processed by eMedNY's Claims Processing System. In the current process the vendor creates a STUB file of specific data elements from the adjustment and void transactions. The vendor then FTPs (file transfer protocol) this file to a designated server at eMedNY. Claims are processed and results are FTP back to the vendor.

36. Will the NY DOH provide the data back to Jan 1, 2007, as specified must be maintained by contractor, from prior to contract initiation? (RFP pg. 35 – Data requirements)

An extract from eMedNY's Data Warehouse can be provided. You will have to provide the specific data elements required for the adjustment/void process in order for us to develop a query for such a job.

37. Will the current contractor's data system be turned over to the new contractor? (RFP pg. 33)

We will provide the data necessary to conduct the requirements of this RFP. The contractor is expected to have their own data system that satisfies the data requirements described in the RFP.

38. Please explain what the phrase "the evaluation of the organization and processes of care" mean with regard to how UR/QI review and monitoring are conducted? (RFP pg. 13)

The organization of care is how a facility is organized to provide a specific service and the processes of care are the activities that are required to provide a specific service/treatment.

39. The RFP indicates that quality concerns are to be reported by the UR/QI agent as "potential NYPORTS occurrences". To whom should these potential NYPORTS occurrences be reported, the provider or the Department? (RFP pg. 22)

They are to be reported to the facility and the Department of Health.

40. Can the Department provide an example of a "hospital-specific analyses of quality of care reviews" format that it has approved? (RFP pg. 26)

We are looking to the bidder to provide their suggestions for the format.

41. As there is no place on Cost Proposal Form 1 for indirect costs, does this indicate that indirect costs are not permitted, and should be calculated into the direct costs? (RFP pg. 76)

This is a price contract, not a cost. Indirect costs should be included in the total price. The State pays the agreed-to price for each deliverable completed as set forth in the successful bid and resulting contract.

42. For chart review, how is the unit price for the Total Amount Requested to be calculated? Is this meant as a weighted average? (RFP pg. 77)

Yes. $Price_1 \times Activity_1 = Bid\ price\ for\ activity\ 1$ $P_2 \times A_2 = Bid\ price\ for\ activity\ 2$, etc. These activity prices are then added to determine the total bid.

43. The RFP indicates that payment is based on successful completion of deliverables, and explains how QIP activities will be paid. For UR activities, does this mean the contractor will be paid according to how many reviews are completed in the quarter, multiplied by the specific review cost of each? How are start-up costs to be paid? (RFP pg. 55)

Payment will be based on the proportion of deliverables that are completed at each payment period. The payment methodology will be worked out with the successful bidder and specified in the contract, including the periodicity of payments. Start-up costs will be paid as one lump sum payment based on the successful bidder's cost proposal and final contract.

44. Can the Department provide information on how the transition between the current contractor and a new contractor would be accomplished? Will there be any payment to the new contractor for transition activities? (RFP pg. 55)

The current contractor is required to cooperate to ensure a smooth transition. The bid should be based on workload projections as listed in the RFP plus start-up costs. We anticipate none or very limited transition costs for a new contractor. If there are any miscellaneous transition costs for the new contractor, they can be billed to the State using the unanticipated work category (see Part A Cost Proposal Form 1.3).

45. What is the overall Return on Investment for the current contract?

An analysis of total ROI for the Utilization Review and QIP activities and AIMS Review Activities has not been conducted and is thus not available. We are reluctant to provide ROI data on past performance since there have been so many significant changes in the Medicaid Program.

46. At the Bidder's Conference, Additional NYPORTS and Additional Quality of Care were identified as new responsibilities in this contract. Are there any other new responsibilities that the current contractor is not performing? If so, please specify.

Section III, L Retrospective Utilization Review for Home-Based Services is a new category of review for the upcoming contract award.

47. Please provide the reference information to find the state's defined review process. Does the state have a process of reviewing the medical records and communicating with the provider and/or beneficiary?

We are looking for the bidder to provide a description of their proposed review and communication process which meets the program requirements of the RFP. We generally/routinely do not communicate with beneficiaries with the exception of the Discharge Review Program. Providers are notified on a case by case basis. Summary reports will be sent to the State and providers on a periodic basis as part of the contractors' reporting responsibilities.

48. Does the review process require a letter be sent regarding the review results? If so to whom?

Yes. The providers are sent the results on a case by case basis. The details of the communication process (i.e. format, timing, etc. should be part of the bidders proposal.)

49. Additional NYPORTS Review (2,100 additional cases). NYPORTS reviews are included in the Readmission Reviews and the Mortality/Complications Reviews. What is the universe that is being sampled to produce the additional 2,100 additional cases? (Page 30)

The state will provide these cases.

50. Unanticipated Workload pricing – should the price list be presented as the medium price for the five years? (Page 32)

The price bid will be the amount the State will pay for this work on an hourly basis for the term of the contract

51. On Cost Proposal Form 1, Chart Reviews and Special Studies/Consultant Reviews Total Dollars Requested are shown as separate lines. On Cost Proposal Form 1.1, these two categories are combined with instructions to carry the combined total over to Form 1. Please confirm that the Special Studies/Consultant Reviews (annual volume of 800) Total Dollars Requested

should be broken out on Cost Proposal Form 1.1 and then carried forward as a separate amount to Cost Proposal Form 1.

Cost Proposal Form 1 has been revised. Special Studies/Consultant Reviews is removed as a separate row. These changes are reflected in the forms attachments on the website in Word format

52. UR/QI Technical Proposal Form 1 has the following "Activity" lines: (1) UR Medical Record Review, (2) D&T Surveys, (3) Home-Based Services Retrospective Case Reviews, (4) Home-Based Services Prior Approval, (5) QIP 1 and (6) QIP 2. The UR/QI Cost Proposal Form 1 has eight categories. The Cost Proposal Form 1 breaks up Utilization and Review into three parts (1) Chart Reviews, (2) Special Studies/Consultant Reviews, and (3) D&T Surveys. It also has a category for "Unanticipated Work". In order to conform the FTE information from the cost proposal to the technical proposal, should the Technical Proposal Form 1 have the same eight categories as the Cost Proposal Form 1?

Technical Proposal Form 1 has been revised to be consistent with Cost Proposal Form 1. These changes are reflected in the forms attachments on the website in Word format

53. Are review nurses (RNs) required to be licensed in New York State to perform either on-site and/or off-site reviews?

Yes

54. Are physician reviewers required to be licensed in New York State to perform reviews?

Yes

HOME-BASED SERVICES

55. What type of providers does home-based services include? (RFP pg. 24)

The term home-based services type providers can include Certified Home Health Agencies (CHHA), Long Term Home Health Care Programs (LTHHCP), Licensed Home Care Services Agencies (LHCSA), Limited Licensed Home Care (LLHCSA), and Private Duty Nurses (PDN). However, the Department is limiting the scope of the Home-Based Services initiative under this RFP to CHHA services as noted below.

What other home-based services, in addition to CHHA and personal care services, are to be included?

This project is to be limited to only CHHA services which are provided on a long-term basis, considered to be over 120 days in duration.

What is the volume of reviews over the last 5 years by year and the length of time to reviews (i.e. home skilled reviews, home health aid, private duty nursing)?

This is a new project and no historical review data is available.

What criteria are currently being used to complete these reviews?

DOH has not established criteria for this project. The successful bidder will develop meaningful criteria and protocols for appropriateness of CHHA services provided in the community on a long-term basis for DOH's review and approval.

56. Section III.L.1 (page 24) mentions CHHAs and personal care services, but does not specifically mention Home and Community Based Services (HCBS) waivers. Is HCBS included in the retrospective utilization review scope of work?

No, Home and Community Based Services waivers are not included in this project. This project is to be limited to CHHA services which are provided on a long-term basis, considered to be over 120 days in duration. However, waiver participants who are in receipt of long-term CHHA services may be included in this UR project, but only to the extent of the CHHA services provided, not to waiver services.

57. Is the current contractor conducting retrospective utilization review for personal care services? If yes, how does this activity relate to the prior authorization of personal care services performed by local social services districts (LDSS) pursuant to NYS regulations? (RFP pg. 24-25)

No. The current contractor is not conducting utilization review for personal care services. There is no relationship with prior authorization of personal care services performed by the LDSS.

58. Several questions were asked regarding the Prospective Case Review with Prior Approval section of the RFP. (RFP pgs. 25-26)

DOH is withdrawing the Prospective Case Review with Prior Approval project from this RFP. DOH is not intending to advance prior approval regulations for long-term CHHA services at this time. Please refer to the Amendments posted on the website for specific pages and text that have been deleted.

PART B: AIMS REVIEW ACTIVITIES

59. The RFP requires a description of how a transfer of documents and information from the current contractor to the new contractor would be implemented. Can the Department provide more information as to what would be transferred, including timeframes and assistance from the current contractor and/or the Department? (RFP pg. 171)

The contractor is required to maintain several databases, as referenced throughout the RFP. The raw data which populates the databases for the current contractor would need to be transferred. The current contractor is required to cooperate to ensure a smooth transition. The start-up period begins January 1, 2009. The new contractor is expected to have their systems up and running to begin reviews on April 1, 2009.

60. Will there be any payment to the new contractor for transition activities? (RFP pg. 171)

Start-up costs should be included in the bid. Please see the cost proposal forms.

61. Please provide an explanation of Attachment 15. What does 3 reviews per eligible patient mean, i.e., does this mean the 3 reviews of the same type are required each time the patient is reviewed, or that the same patient is reviewed for this type of review 3 times a year, or something else? (RFP pg. 251)

Attachment 15 explains how the indicators are weighted according to complexity. The weights can be used to determine your cost for a particular indicator, based on your unit review cost. For example, for VL (viral load) outcomes, the review is weighted as 3 reviews for the VL measurement component and 1 review for the Substance Use component. So your cost per patient would be your calculated unit cost times four.

62. Please explain how Attachment 13 (One Year Projected Review Allocations) and Attachment 15 (Review Counts by Review Type) relate to one another. (RFP pgs. 244, 251-252)

Attachment 13 is a projection of the total number of annual reviews anticipated for each of the programs listed. Attachment 15 explains the weight of reviews by patient. So, for example, if a facility had a patient sample size of 10 for the VL Outcomes that would translate to 40 reviews. The number of reviews listed in Attachment 13 for each type of program has already included the weights.

63. The AIMS RFP Attachment 15, has six adolescent categories on the chart. Please confirm that these are all adolescents and none apply to adult reviews?

Thank you for this observation. Of the six columns listed as adolescents, the first four should not say adolescents. They should be:

*Males 13+, DACs, nonDACs, CHCs
Females 13+, DACs, nonDACs, CHCs
Males 13+, DTCs,
Females 13+, DTCs*

The remaining two columns should read as they are:

*Adolescent Males 13-21
Adolescent Females 13-21*

64. Does the estimated number of hours assume that the current contractor has already conducted some of the work on these projects? If so, how would this affect a new contractor? Should these estimated hours be used as a standard by all bidders for their cost proposals? (RFP pgs. 245-250)

The number of hours provided excludes the actual review time. The tasks that are included in the projected hours are listed in Attachment 14 (One Year Projected Data Analytical Effort by Project). A contractor is expected to develop their own systems and tools for completing and reporting on review outcomes. The estimated hours apply to all bidders.

65. Please explain what is meant by “surveillance tools”. (RFP pg.174)

Surveillance tools are the tools you would use to identify population and sample sizes in facilities subject to reviews.

66. Please explain what is meant by “Each medical record selected for review is estimated to require the application of up to ten independent quality of care review tools.” (RFP pg.176)

Please refer to the HIV Guidelines website listed in Part B, Attachment 16 of the RFP for the list of core and optional indicators that apply to reviews. The number of indicators may change from year to year, but the “application of up to ten” has been the experience historically.

67. Will the contractor receive historical Medicaid and UR data files from the previous contractor or from the Department for analytical purposes? (RFP pg. 183)

The contractor will receive historical Medicaid and UR data files from both the previous contractor and the Department.

68. How many copies of the Technical Proposal for Part B: AIMS Review Activities are required to be submitted? (RFP pg. 185)
An original and 5 copies of the Technical Proposal are required for Part B: AIMS Review Activities. Part A: Medicaid Utilization Review and Quality Improvement Activities also requires one original and 5 copies of the Technical proposal.
69. Submission requirements state 12 pt. font must be used. Does this also apply to tables and charts? (RFP pg. 185)
The narrative portion of the Technical Proposal must be in 12 pt. font. Tables and charts are not required to be in 12 pt. font.
70. At the Bidder's Conference, the value of the current contractor's Part A (Medicaid UR and QI) was given at \$23,310,000 for the period 4/1/06-3/31/08. Please provide similar information, including an annual breakdown, of the current contractor's Part B (AIMS) contract.
\$2,560,000 in State funding and \$790,000 in Federal funding annually.
71. Are there any new responsibilities in this contract that the current contractor is not performing? If so, please specify.
The types of responsibilities have not changed substantively, but there are changes in both volume and distribution of reviews and in related data analysis and reporting requirements. Bidders should determine their pricing using the volume of reviews and data requirements outlined in Attachments 13 and 14.
72. The AIMS RFP requires that the proposal be double spaced and further requires that the executive summary be no more than two pages. The list of things that must be included in the Executive summary (Section IV.B.3.) is very extensive and it would appear that two double-spaced pages may be insufficient to cover all of the required information. Will DOH either delete or revise the page restriction for the Executive Summary in the AIMS Proposal?
We will eliminate the page limitation for the AIMS Executive Summary and permit single spacing.

73. Will DOH consider lifting the double space requirement for the AIMS Proposal in the interest of saving paper? If not, does the double spacing requirement apply to tables and charts? Please note that the double spacing requirement does not apply to the UR/QI Proposal.

Yes, in the interest of saving paper, the proposal may be single-spaced. Tables and charts are exempt from formatting requirements but must be easily readable.

74. Will a Data Exchange Application and Agreement (DEAA) be required before MMIS data can be exchanged with the contractor?

Yes

75. Section IV.B. Technical Proposal requires that “Understanding of Work” be placed as the last section (7) of the proposal. Can the bidder have the option to move “Understanding of Work” to follow Section 3 (Executive Summary), similar to its placement in the UR/QI proposal (Page 47, second bullet)?

It is best to adhere to the order provided in the RFP, as that is the order that the reviewers will be expecting as they go through the scoring process. Variation from the expected order could result in a reviewer missing a response. In the AIMS proposal, the Understanding of the Work section is the bidder’s opportunity to sum up and reinforce what has been described in detail in prior sections.

76. Section IV.B.4. requires inclusion of the bidder’s experience, including “experience with the creation, manipulation and ongoing analyses of large scale data systems; experience with epidemiologic and demographic data analyses, health service analyses, benchmarking and other relevant activities”. Section IV.B.6. requires inclusion of the bidder’s experience, including “experience and current ability to conduct sophisticated epidemiologic and demographic analyses”. Should the relevant experience be included in both the Organization and Personnel section and the Data Management and Reporting section? If it should only be in one of the sections, which section should it appear in?

There are subtle differences between these sections. Section IV.B.4 has a programmatic focus that includes data manipulation and analysis. Section IV.B.6 has a data focus that supports the program activities. Since there is overlap, but each section will be scored individually, it would be best to include relevant experience in both sections, even though there may be repetition.

77. Section IV.B.5. requires inclusion of methods and procedures for meeting data requirements (last bullet in the first bullet list), with some details of what should be included/addressed in Section IV.D.2.e.v. (last bullet). All of the details

relating to data requirements appear in Section IV.B.6. (Data Management and Reporting). Should the subject be addressed in both places? If so, what specific information should be included in Section IV.B.5., that isn't already included in Section IV.B.6.?

It is possible that the sections may be scored by different reviewers. There will be data experts reviewing the Data Management and Reporting section. If there is overlap in response content, it is best to repeat as needed.

78. The Bidder's Assurances Form (Attachment 2) is included in the AIMS RFP attachments but is not included on the AIMS proposal submission checklist. Please confirm whether or not this form is required for submission with the AIMS proposal.

This form is required for submission with the AIMS proposal.

79. The NYS Taxation and Finance Form (ST-220-TD) - RFP Attachment 7 and NYS Taxation and Finance Form (ST-220-CA) - RFP Attachment 8 are included in the AIMS RFP, but are not included in the AIMS proposal checklist. Please confirm whether these forms are required for submission with the AIMS proposal.

Attachments 7 and 8 are required for submission with the AIMS proposal.

80. Attachment 3 (Bid Form), item A, requires the entry of "total price" – is this amount the total price for the five year period of the contract or the first year amount?

The total price is the price for the five year period of the contract plus start-up costs.

81. AIMS Cost Proposal Form 1.1 in Item E has a phrase with an asterisk (Specify what included here*). There is no single asterisk statement to which this refers. Is there something missing from the form? What should be addressed in response to that asterisked statement and where should that information be placed?

Bidders may roll their data analysis costs into the unit cost for review activities, or they may bid them separately, referencing Attachment 14. The latter can be itemized on a separate page(s) attached to Form 1.1. A third option: bidders may include some analysis in their review costs but develop a separate hourly rate for data activities that aren't tied directly to reviews.

Attachment Question #27 – Psychiatric Criteria

file
Parish
Carton

To Hospital Administrator:

January 15, 1997

Medicaid regulations require that each state meet certain conditions to participate in the program. These include regular review activities to ensure that inpatient hospital services are appropriately utilized and that the quality of care provided meets acceptable standards. The Department of Health contracts with the Island Peer Review Organization, the federally appointed PRO for this region, to conduct these reviews.

Historically, psychiatric patients composed only a small percentage of the total number of cases reviewed. However, retrospective reviews covering admissions in 1993, 1994, and 1995 were initiated this past year, and the volume of psychiatric cases increased significantly. In addition, plans have been made to review about 35% of the total number of Medicaid eligible individuals receiving inpatient hospital services in 1996 and thereafter.

The criteria governing IPRO review decisions to date have been those promulgated by DOH Hospital Memorandum 77-86 in September of 1977.

Since there have been many changes in psychiatry in the past twenty years, it became important to update the criteria. This has been accomplished through the efforts of a workgroup composed of representatives of the following organizations:

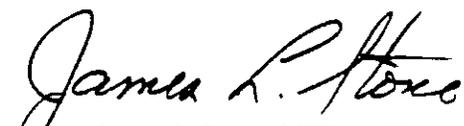
- The New York State Psychiatric Association
- The Greater New York Hospital Association
- The Healthcare Association of New York
- The Mental Health Services Council
- The Island Peer Review Organization
- The New York City Department of Mental Health, Mental Retardation and Alcoholism Services
- The Department of Health
- The Office of Mental Health
- The New York Psychiatric Institute, and several hospitals.

The new criteria, which are attached, are consistent with Medicaid regulations and similar to the 1977 criteria in many respects. However, there are some important changes which warrant your careful review. These criteria should serve as an adjunct to clinical decision-making in matters of admission, continued stay, and documentation. It is important that the documentation accurately reflect the rationale behind the clinical decisions made.

In the near future, you will receive a document which explains these criteria in greater detail and provides examples which may be useful to your clinicians in decision-making. It is our intent and hope that these criteria will provide a basis for mutual understanding of appropriate admission and continued stay decision-making among providers of service, reviewers, patients, and their families.

Sincerely,


Barbara A. DeBuono, MD, MPH
Commissioner, Department of Health


James L. Stone, MSW, CSW
Commissioner, Office of Mental Health

Effective February 17, 1997

**CRITERIA FOR ADMISSION AND CONTINUED STAY
OF PERSONS OVER THE AGE OF 16 YEARS
TO PSYCHIATRIC UNITS OF GENERAL HOSPITALS**

I. ADMISSION CRITERIA

The necessity and appropriateness of admission to hospital level of care shall be substantiated by one or more of the following:

- A. Behavior or thought by the patient or a history of behavior or thought by the patient that, in the professional judgment of a psychiatrist, is likely to lead to consequences which are a significant danger to the patient or others.**
- B. Behavior exhibited by the patient which is no longer tolerable to the patient or to society and is, in the professional judgment of a psychiatrist, likely to be ameliorated by treatment at this level of care.**
- C. Ambulatory treatment has been unsuccessful in halting or reversing the course of the mental illness, and inpatient treatment at this level of care is needed in order to prevent or manage (A) or (B) above.**
- D. The patient requires medication, electro-convulsive therapy, or other treatment which cannot be initiated or continued unless in a supervised setting at this level of care.**
- E. The patient has a general medical condition other than a mental disorder which requires hospital level of care, but the concurrent psychological aspects of the disorder cannot be handled as well on other units.**
- F. The patient has a significantly complex clinical presentation, requiring comprehensive assessment and evaluation or a period of continuous observation in order to make a definitive diagnosis and treatment plan.**
- G. The patient meets the standards for any involuntary commitment.**

II. CONTINUED STAY CRITERIA

The necessity and appropriateness of continued stay at the hospital level of care shall be substantiated by any of the following:

- A. There is physical danger to the patient or others, and no other level of care is appropriate.**
- B. The behavior of the patient remains intolerable to the patient or society, and clinical evidence recorded in the medical record justifies an extension of stay at this level of care under active treatment, and no other level of care is appropriate.**
- C. If the patient were to be discharged, (A) or (B) above would be likely to recur soon, and continued hospitalization is necessary to prevent this. The medical record must document the history, current findings, the reason why it is believed likely to recur soon, and why continued hospitalization is necessary to prevent this recurrence.**

Although the patient may have improved significantly, a period of observation may be necessary to ensure that the gains made are lasting. Such observation requires a clear rationale documented in the progress notes of the medical record and, as appropriate, a revision of the discharge plan.

- D. The patient's recovery depends on the use and regulation of a specific modality such as medication, but the patient lacks motivation, refuses to cooperate, or would be unable to cooperate with the treatment plan under a program of ambulatory care or care at another level. Documentation must reflect that if one approach to treatment fails to bring about results within expected or reasonable timeframes, other approaches to treatment are initiated.**
- E. A major change in the patient's clinical condition such as an unexpected setback requires extended treatment, and evidence suggests that the patient can improve sufficiently to be treated in an ambulatory setting or other level of care only after additional hospitalization and a different course of treatment.**
- F. The patient has a general medical condition other than a mental disorder which requires hospital level of care, but the concurrent psychological aspects of the disorder cannot be handled as well on other units.**

III. DOCUMENTATION

The medical record must clearly document the need for hospital level of care, provide evidence of active treatment in accordance with the treatment plan, and record observations of the patient's response to treatment.

The medical record should contain the following, each of which should provide evidence of the need for or the actual provision of active treatment:

- o Admission notes completed at the time of admission which document the rationale for admission, the need for hospital level of care, diagnostic impressions, and treatment recommendations.
- o History and physical examination completed within 24 hours of admission or a note indicating that an attempt was made, but that it was impossible due to the patient's inability or unwillingness to cooperate.
- o Progress notes written each day for the first five working days, and thereafter, no greater than three days apart and no less than three times a week, as well as whenever any significant changes or adverse events occur.
- o A specific written treatment plan recorded within three working days of admission.

In addition to the above, the record should also contain a discharge plan initiated as soon as possible and recorded no later than the fifth working day after admission and reviewed weekly thereafter.

The contents of the Admission Note, the Treatment Plan, Progress Notes, and Discharge Plan should include, but not be limited to, the following:

A. THE ADMISSION NOTE

- o should provide a rationale for why hospital level of care is needed;
- o should contain diagnostic impressions;
- o should make initial treatment recommendations;
- o should document results of the mental status exam.

B. THE TREATMENT PLAN

- o should identify the patient's strengths and problems to be addressed during hospitalization;
- o should be based on a comprehensive review of the history, physical exam, mental status exam, and psychosocial assessment;
- o should identify individualized behaviorally-oriented objectives and short and long range goals;
- o should list specific treatment modalities and interventions, as well as responsible disciplines or persons for each.

C. PROGRESS NOTES

- o should record observations of the patient's responses to medication and other treatments such as ECT and behavioral and psychotherapeutic interventions;
- o should be directly related to the patient's treatment plan;
- o should reflect the patient's clinical status and clinical changes, as well as a summary of interventions;
- o should document evidence of continued active treatment as provided;
- o should provide justification of the need for continued stay at the hospital level of care as appropriate.

D. THE DISCHARGE PLAN

- o should identify the disposition and specific level of care needed on discharge;
- o should identify the specific services needed to maintain the patient out of the hospital;
- o should identify family or other supports needed to maintain the patient outside of the hospital;

- o should identify the fiscal resources needed to maintain the patient outside of the hospital;
- o should contain evidence of the pursuit and arrangement of the identified services, familial or other supports, and fiscal resources needed to maintain the individual outside of the hospital.

E. SIGNATURES

A member of the medical staff who has privileges to admit patients shall assume the principal obligation and responsibility for managing the patient's medical care. Post-graduate trainees and supervising physicians shall consult with and be directed by the attending practitioner with regard to therapeutic decisions and changes in patient status. Active treatment must be documented in the record by notes written by the attending physician or by the medical student, intern, or first year resident and countersigned by the attending physician or senior resident.

INTERPRETIVE GUIDELINES TO BE USED IN CONJUNCTION WITH
THE CRITERIA FOR ADMISSION AND CONTINUED STAY OF PATIENTS
ADMITTED TO PSYCHIATRIC UNITS OF GENERAL HOSPITALS

February 17, 1997

I. INTRODUCTION

On September 30, 1977, The Department of Health issued a Hospital Memorandum entitled, "Criteria and Standards for Admission of Persons Over the Age of 16 Years to Psychiatric Units of General Hospitals." These criteria and standards which address admission, continued stay, alternate care placement, and documentation, have been used by the Medicaid review agent in New York State, the Island Peer Review Organization (IPRO) in the retrospective reviews of the utilization of inpatient psychiatry services by Medicaid patients.

However, the field of psychiatry has changed dramatically over the past twenty years, and a decision was made to revise the 1977 criteria and standards to reflect these changes and the impact they have had on treatment. The revised criteria, effective February 17, 1997, are similar in many ways to those promulgated in 1977, but there are a few changes, as well as some new interpretations and clarifications which will apply both retrospectively and to those cases in which the patient was admitted on 2/17/97 or thereafter.

This document is intended to provide clarification on a number of issues which arose out of the initial retrospective psychiatric reviews. It is not intended as an all-inclusive guidebook. Rather, it addresses those specific areas in which there was obvious confusion or where questions were frequently asked. For example:

- o How is medical necessity defined?
- o What constitutes active treatment?
- o Is observation a legitimate function under the treatment plan?
- o Must medication be changed to demonstrate active treatment?
- o When should a patient be placed on alternate level of care status?
- o Does referral to another hospital mean that the patient should be placed on ALC status?

- o If a patient denies suicidality, does that mean hospital level care is no longer reimbursable?
- o Does the recommendation for transfer to an OMH hospital mean that the patient should be placed on ALC status?

All of these questions were reviewed and considered by The Psychiatric Review Workgroup and by additional staff within DOH, OMH, and IPRO. The interpretations provided here reflect their deliberations, as well as the information available from a number of Federal and State regulations and guidelines, which are listed in the last section. In the interest of clarity, the language of some of these documents has been used word for word.

Most of the questions fell into two major groups:

1. Those associated with care provided to individuals for whom hospital level care is necessary, and;
2. Those associated with care for individuals for whom hospital level care is no longer necessary.

The next two sections are structured accordingly and are followed by a brief section on documentation and, finally, a section listing source documents.

II. WHEN HOSPITAL LEVEL CARE IS NECESSARY

An individual requires hospital level care when he or she meets the Criteria for Admission and Continued Stay of Persons Over the Age of 16 Years to Psychiatric Units of General Hospitals. When these criteria are met, medical necessity for hospital level care is established.

A. MEDICAID REIMBURSEMENT FOR HOSPITAL LEVEL CARE

Reimbursement is available for all Medicaid eligible patients who need hospital level care and who are receiving active treatment in such a setting.

For a hospital to claim reimbursement for inpatient hospital care, all of the following must be met:

1. The patient must meet Medicaid eligibility requirements;
2. The patient must need hospital level of care as demonstrated by meeting the criteria for admission and continued stay;
3. The patient must be receiving active treatment in accordance with an individualized treatment plan;
4. The treatment provided and the patient's responses to treatment must be documented in the medical record.

B. ACTIVE TREATMENT

For services to be considered active treatment, they must be:

1. provided under an individualized treatment or diagnostic plan;
2. reasonably expected to improve the patient's condition or for the purpose of diagnosis, and;
3. supervised and evaluated by a physician.

Diagnosis, length of hospitalization, and the degree of functional limitation are not factors in determining whether services provided constitute active treatment.

Services provided randomly or without regard to an individualized treatment plan would not constitute active treatment, even though they might be therapeutic in nature. Rather, the services must be provided in accordance with an individualized program of treatment or diagnosis developed by a physician in conjunction with staff members of appropriate other disciplines on the basis of a thorough evaluation of the patient's restorative needs and potentialities.

In addition, the services must reasonably be expected to improve the patient's condition or be rendered for diagnostic purposes. It is not necessary that a course of therapy have as its goal the restoration of the patient to a level of functioning which would permit discharge. However, the treatment must, at a minimum, be designed to reduce or control the patient's psychotic or neurotic symptoms which necessitated hospitalization and improve the patient's level of functioning.

Psychotherapy, drug therapy, ECT and adjunctive therapies such as occupational therapy, recreational therapy, and milieu therapy all would be examples of active treatment, as long as they are provided in conjunction with an individualized treatment plan and they can be expected to result in improvement. However, if the primary interventions are solely diversional in nature rather than therapeutic and not, in and of themselves, expected to result in improvement in the patient's condition, they would not be considered active treatment.

The services provided to the patient must be supervised and evaluated by the physician. They may be provided by other clinical staff, but must be prescribed and directed by a physician to meet the specific psychiatric needs of the individual. It is the responsibility of the physician to periodically evaluate the therapeutic program and determine the extent to which treatment goals are being realized and whether changes in direction or emphasis are needed.

The period of time during which a patient is receiving active treatment should include all days on which inpatient psychiatric hospital services were provided because of the individual's need for active treatment - not just the days on which specific therapeutic or diagnostic services were rendered. For example, a patient's program of treatment may necessitate the discontinuance of therapy for a period of time, or it may include a period of observation - either in preparation for, or as a follow-up to, therapy -while only maintenance or protective services are furnished. If such periods were essential to the overall treatment plan, they would be regarded as part of the period of active treatment.

C. OBSERVATION

The nature of mental illness, what we know about recovery, and the effect of different psychotropic medications, indicate that the resolution of symptoms occurs in an uneven fashion. Marked improvement characterized by periods of calm and stability may be punctuated by regression and instability. Although an individual may appear to be stable, in fact, a period of observation may be required to determine whether the course of treatment is actually producing the desired results, whether the gains are lasting, and whether further adjustments in medication are needed. Such a period of observation constitutes active treatment reimbursable at the hospital rate, as long as the rationale for observation is documented and regular progress notes are recorded.

D. CHANGES IN CLINICAL CONDITION

Frequently, recovery does not occur in a linear fashion and, at times, there may be disagreement between the patient and the clinician or even among clinicians about where the patient is in the process. Therefore, a simple statement by the patient that he or she is not suicidal, for example, or not experiencing a specific psychotic phenomenon or is not otherwise symptomatic does not necessarily indicate that he or she is ready for discharge or even a lower level of medical care. Rather, such a statement should be considered along with all other relevant clinical factors in assessing the patient's clinical status. Movement to a reduced level of care based solely on the patient's assessment is not warranted.

In some cases, a patient may have been moved appropriately to alternate level of care status, but, while awaiting discharge, relapsed to the point where active treatment in a hospital is once again necessary. In such cases, the patient should be removed from ALC status and returned to hospital level of care. The relapse should be documented, and a new treatment plan developed reflecting the need for active treatment.

E. MEDICATION

There is no requirement that the patient's medications or dosages of medications need to be changed at any particular time intervals in order to meet the criteria for active treatment at the hospital level of care, so long as the medication treatment plan meets generally accepted clinical standards for appropriate dosing and duration of clinical trial for a documented diagnosis. There is also no requirement that the patient be on medication at all if such an approach meets generally accepted clinical standards and is documented in the treatment plan. If medication is refused by the patient, this should be documented and appropriate steps taken according to hospital policy.

F. THERAPEUTIC LEAVE

Therapeutic leave may be included and reimbursed within a period of active treatment, if consistent with the patient's treatment plan and with the institution's written policy on the use of leaves for therapy only. Therapeutic leave is limited to two days for any single leave, and is not reimbursable for individuals hospitalized less than fifteen days. A patient is considered absent overnight when he or she is absent later than the time at which the hospital normally conducts its patient census. Reimbursement is not available for patients who return from leave and are subsequently discharged within twenty-four hours.

G. TRANSFER TO ANOTHER HOSPITAL

A person for whom inpatient care remains medically necessary, but for whom transfer to a different hospital, including a State or private psychiatric hospital, or another general hospital, is being sought, and who continues to receive active treatment pending such placement, continues to be reimbursable at the hospital rate. Such transfers may be necessary for many reasons, including the need to access specialty services, the need to relocate the patient closer to family, or the need for similar services, but in a more secure setting or structured milieu, or for an extended period of active treatment in another hospital. A key distinguishing factor is the need for and provision of active treatment in a hospital setting.

The decision to recommend transfer to another hospital, including state psychiatric centers, does not, in and of itself, determine the hospital is eligible for reimbursement at the hospital level of care. The continued need for hospital level care must be justified and documented in the medical record. In addition, active treatment must continue to be provided and documented through regular progress notes.

Reimbursement for continuing care to those patients who must remain in the general hospital while awaiting transfer to a psychiatric hospital may be covered only if there is documentation in the medical record of contact with the receiving psychiatric hospital or unit, request for immediate admission, and a plan for transfer and continuing treatment.

H. DANGEROUSNESS

The 1977 memorandum addresses behavior or thought by the patient, that in the judgment of a psychiatrist, is likely to lead to consequences that are a danger to the patient or others. In addition to current thought or behavior, a clinician may consider a patient's past history in making a clinical judgment about whether the patient would be likely to present a danger to self or others if discharged. Consideration may be given to a variety of factors such as history of relapse upon prior discharges, reversion to chemical abuse, violent behavior, or engagement in dangerous activities in the past.

I. INVOLUNTARY COMMITMENT

If the patient is Medicaid-eligible and meets the standards for any involuntary commitment, the admission criteria are presumed met. Active treatment at the hospital level of care must be documented in the same manner as for any other admission.

J. PRIMARY MEDICAL DISORDER

An individual may be admitted to the hospital for medical or surgical purposes, but experience psychological distress or psychiatric symptoms coinciding with his or her medical condition. Although such individuals would ordinarily be treated on a medical/surgical unit, the psychological aspects of the disorder may indicate that the patient would be better served in a psychiatric unit. Reimbursement is available for such individuals provided that the rationale for treatment on the psychiatric unit is documented.

III. WHEN HOSPITAL LEVEL CARE IS NO LONGER NECESSARY

An individual no longer requires hospital level care when he or she ceases to meet the criteria and standards for continued stay. At such time, the patient should be discharged to the least restrictive clinically appropriate site, in accordance with hospital discharge planning requirements. A person for whom discharge has been determined to be appropriate, but for whom no clinically appropriate site is available, should be treated as follows:

- A. **Alternate Level of Care Services:** If it has been determined that inpatient hospital services are no longer medically necessary, but that a lower level of post-hospital medical care services are medically necessary, are not otherwise available, and are being provided by the hospital; the hospital should place the person on alternate level of care status consistent with utilization review standards.

Alternate level of care services include any non-hospital level of care that is medically necessary, such as those that may be provided by intermediate care facilities, nursing facilities, day treatment programs, or mental health clinics.

The hospital should document in the patient record the level of care required by the individual, why the patient cannot be discharged to that level of care or another setting at this time, the fact that the hospital is providing at least that level of care, and the efforts undertaken to place the individual in a setting providing that level of care. Services provided to that individual are reimbursable at the established alternate level of care rate.

- B. **Non-Reimbursable Stay:** If it has been determined that inpatient hospital services are no longer necessary, and that a lower level of post-hospital medical services are no longer medically necessary, the person awaiting discharge is not reimbursable at either an inpatient or alternate level of care rate.

IV. DOCUMENTATION

The medical record serves as a primary tool for structuring treatment planning and discharge planning and for recording observations of the patient's response to treatment and readiness for discharge. The medical record also serves as a means of communication among clinicians and reviewers who must rely on the record for information to answer questions about medical necessity and active treatment. As such, the medical record must clearly document the need for hospital level of care or other level of care as appropriate, provide evidence of active treatment in accordance with the treatment plan, and record observations of the patient's response to treatment.

V. SOURCE DOCUMENTS

The following were used as source documents for the Interpretive Guidelines:

Social Security Act Titles XVIII (Medicare) and XIX (Medicaid)
Title 42 Code of Federal Regulations (Medicare & Medicaid)
Article 9, New York State Mental Hygiene Law
Title 10, New York Code of Rules and Regulations (Health)
HCFA Medicare Intermediaries Manual