



To: All Health and Recovery Plans (HARPs) and HIV Special Needs Plans (HIV SNPs)

Subject: Policy for Improving Access to Adult Behavioral Health Home and Community Based Services (BH HCBS) for HARP and HARP-Eligible HIV Special Needs Plan Members *Not Enrolled in Health Homes*

Purpose: To ensure HARP members and HARP-Eligible HIV SNP members (hereinafter, “HARP members”) who are not currently enrolled in a Health Home are given the opportunity to access Adult BH HCBS, the State has established the following processes and protocols for HARPs and HIV SNPs contracting with Designated Entities.

It remains the State’s priority to work towards Health Home enrollment for all HARP members, so that members may benefit from enhanced care coordination and integrated care planning services designed to promote ongoing engagement in care. For HARP members not enrolled in Health Home, the most effective education and engagement into critical new services may occur through existing therapeutic or supportive working relationships. These providers are often best positioned to help the member understand the benefit of BH HCBS and Health Home, identify recovery goals, and link directly to services.

Effective April 1, 2018, in accordance with Appendix T of the Medicaid Managed Care/Family Health Plus/HIV SNP/Health and Recovery Plan Model Contract (Model Contract), HARPs and HIV SNPs will contract directly with **State Designated Entities (SDEs)** for the purposes of performing Adult BH HCBS assessment, referral, and HCBS Plan of Care development for HARP members that are not currently enrolled in a Health Home.

I. The following entities are authorized as State Designated Entities (SDEs):

Agencies or community-based organizations that are state-designated Health Homes, or affiliated with a Health Home, and who employ individuals meeting the NYS assessor qualifications for Adult BH HCBS. An agency is considered affiliated with a Health Home when the agency has a contractual relationship with a NYS-designated Health Home for the provision of health home care management services. The State will provide a list of all State Designated Entities eligible to contract as Recovery Coordination Agencies (RCA) for Adult BH HCBS.

Note: If a HARP/HIV SNP would like to work with a provider agency not contained in the SDE Eligible Agencies list provided by the State, the HARP/HIV SNP should contact the State for review of the agency’s status.

II. Individuals providing assessment and care planning for contracted RCAs are referred to as Recovery Coordinators.

Recovery Coordinators can be either:

- A. employed as a care manager or care management program supervisor within the Agency; or
- B. employed, associated with, or contracted for work with another program within that Agency (such as a housing or clinical program).

Staff completing the NYS Eligibility Assessment must meet the NYS Adult BH HCBS Assessor qualifications:

Education and Experience

- 1. A Master's degree in one of the qualifying¹ fields and one (1) year of Experience; OR
- 2. A Bachelor's degree in one of the qualifying fields and two (2) years of Experience; OR
- 3. A Credentialed Alcoholism and Substance Abuse Counselor (CASAC) and two (2) years of Experience; OR
- 4. A Bachelor's degree or higher in ANY field with either: three (3) years of Experience, or two (2) years of experience as a Health Home care manager serving the SMI or SED population.

Experience must consist of:

- 1. Providing direct services to people with Serious Mental Illness, developmental disabilities, alcoholism or substance abuse, and/or children with SED; OR
- 2. Linking individuals with Serious Mental Illness, children with SED, developmental disabilities, and/or alcoholism or substance abuse to a broad range of services essential to successful living in a community setting (e.g. medical, psychiatric, social, educational, legal, housing and financial services).

AND

Supervision

Supervision from someone meeting any one of the following:

¹ **Qualifying fields** include education degrees featuring a major or concentration in: social work, psychology, nursing, rehabilitation, education, occupational therapy, physical therapy, recreation or recreation therapy, counseling, community mental health, child and family studies, sociology, speech and hearing or other human services field.

1. Licensed level healthcare professional² with prior experience in a behavioral health setting; OR
2. Master's level professional with two (2) years prior supervisory experience in a behavioral health setting.

AND

Training

Completion of:

- a. Specific training on the array of services and supports available, person-centered care planning process, and assessment of individuals whose condition may trigger a need for HCBS and supports; and
- b. Mandated training on the New York State Eligibility Assessment instrument; and
- c. Additional training as required by the State.

III. Scope of work for the Recovery Coordination Agency:

Assessment:

- Conduct the NYS Eligibility Assessment, annually or more often as needed

Person-Centered Care Planning:

- Work with the HARP member to identify recovery goals and the BH HCBS that will help the member achieve their goals
- Request the Level of Service Determination
- Offer choice of BH HCBS Providers to the member
- Make referrals to appropriate BH HCBS
- Develop and maintain the Adult BH HCBS Plan of Care

IV. The Recovery Coordination Agency shall adhere to the following protocols:

1. Recovery Coordinators will:
 - a. Have a thorough knowledge and understanding of:
 - i. Adult BH HCBS benefits;
 - ii. Health Home care management; and
 - iii. The Adult BH HCBS Workflow, available [here](#).
 - b. Educate HARP members about the benefits of Health Home services including ongoing coordination of BH HCBS, encourage enrollment in Health Home, and if

² **Licensed level healthcare professional** includes: Physicians, Psychiatrists, Physician's Assistants, Nurse Practitioners, Psychiatric Nurse Practitioners, Registered Professional Nurses, Licensed Practical Nurses, Licensed Psychologists, Licensed Clinical Social Workers, Licensed Master Social Workers, Licensed Mental Health Counselors, Licensed Marriage and Family Therapists, Licensed Psychoanalysts, Licensed Creative Arts Therapists, and Licensed Occupational Therapists.

interested (and with the member's consent), refer to or upward enroll the member in the Health Home.

2. RCAs may receive referrals directly from the MCO and proceed with providing recovery coordination services right away. In the event an RCA receives a referral from another source, including internally within the agency, the RCA must notify the member's MCO prior to providing services to ensure that the individual is not currently served by another Recovery Coordinator or Health Home care manager.
3. Conduct the NYS Eligibility Assessment for Adult BH HCBS. Recovery coordinators will use the NYS Eligibility Assessment to determine a HARP member's eligibility for BH HCBS (Tier 1, Tier 2, or Not Eligible for HCBS). Recovery coordinators must complete required training prior to conducting assessments; see [UAS-NY User Support](#) for more information.
4. Engage in a person-centered HCBS Plan of Care discussion with the member to help identify recovery goal(s) and to recommend Adult BH HCBS that may help the member reach his/her goals. See [Federal Adult Behavioral Health HCBS Person-centered Planning Process Requirements/Characteristics](#) for more details.
5. Once determined the member is eligible for and wishes to access BH HCBS, request a Level of Service Determination (LOSD) from the HARP/HIV SNP. The recovery coordinator shall provide the following information:
 - BH HCBS Eligibility (indicating Tier 1 or 2 eligibility);
 - The member's person-centered recovery goal(s);
 - All services the individual currently receives, and
 - BH HCBS the member is interesting in participating.
6. RCAs shall comply with CMS conflict-free case management rules (42 CFR Part 441.301).
7. Offer choice of Adult BH HCBS Providers which are in the member's MCO network.
8. Initiate referrals to BH HCBS providers chosen by the member.
9. Develop an integrated BH HCBS Plan of Care that meets all [federal requirements for BH HCBS plan of care](#), including verification that member was offered a choice of in-network BH HCBS providers. The Plan of Care shall be updated to reflect changes in the individual's needs, goals, BH HCBS eligibility, and/or services needed.
10. Notify the HARP/HIV SNP of all members who:
 - a. completed the Eligibility assessment
 - b. are deemed Not Eligible for Adult BH HCBS
 - c. are deemed Eligible but decline Adult BH HCBS due to:
 - i. choice to remain in a setting that is not home and community-based
 - ii. feel BH HCBS will not help achieve their goals
 - iii. receiving state plan services already meeting their needs; or
 - d. declined the Eligibility assessment.
11. Conduct annual re-assessment for BH HCBS eligibility as required for all HARP members. The recovery coordinator will use the NYS Eligibility Assessment tool to reassess the

individual at least annually, and/or after a significant change in the individual's condition warrants a change to the individual's Plan of Care.

V. HARPs and HIV SNPs must adhere to the following procedures:

1. HARP/HIV SNPs must assist members in accessing Adult BH HCBS either through enrollment in Health Homes or referral to a contracted RCA for the provision of assessment and care planning.
 - a. The HARP/HIV SNP shall offer Health Home enrollment when engaging a HARP member, if such member is not enrolled in a Health Home. This includes individuals who are in outreach, assigned to but not enrolled in a Health Home, opted out of Health Home, or HARP members who were enrolled in Health Home but have been dis-enrolled.
 - b. The HARP/HIV SNP may refer a HARP member to a contracted RCA when the member has expressed interest in Adult BH HCBS and chooses not to enroll in the Health Home program.
2. An MCO may establish a pathway of communication with the LGU/SPOA by which HARP members can be directly referred to the MCOs contracted RCA. The SPOA will provide notification to the MCO of that member's interest and referral to the RCA.
3. Issue Level of Service Determinations. The MCO shall issue a LOSD for requested BH HCBS based on the member's BH HCBS Eligibility (Tier 1 or 2), person-centered recovery goal(s), and any existing services. MCOs should streamline the receipt and issuance of LOSDs as much as possible so as not to delay referrals to BH HCBS. MCO's should have established points of contact for Recovery Coordinators.
4. Work with the RCA to ensure the member is offered a choice of in-network BH HCBS providers consistent with conflict-free care management requirements. Authorize initial evaluation visits with BH HCBS providers as outlined in the Adult BH HCBS Workflow.
5. Review and respond to BH HCBS provider requests for authorization of BH HCBS, as outlined in the Adult BH HCBS Workflow.
6. Ensure the member's Adult BH HCBS Plan of Care is in adherence with [Federal Adult BH HCBS Person-Centered Planning Process requirements](#) and [Federal BH HCBS Plan of Care Requirements](#). The HARP/HIV SNP shall ensure updates are made to the Plan of Care as the member's service needs change.

The MCO shall develop and implement policies and procedures to monitor appropriate implementation of plans of care, including the qualifications of individuals developing plans of care consistent with State guidance, types of assessments conducted and the method for how Enrollees are notified of available services. Provider documentation is subject to review by the State to verify compliance with state and federal requirements for adult BH HCBS.

7. Arrange for reassessment of BH HCBS eligibility as required.

VI. HARP/HIV SNP Network Adequacy Monitoring:

1. In accordance with Model Contract Requirement Section 10.1(d) (*Applicable to the HARP and HIV SNP Programs Only: The Contractor must provide or arrange for the provision of care management and eligibility assessments for Behavioral Health Home and Community Based Services as outlined in Section 10.41*), each MCO must demonstrate Recovery Coordination Agency network adequacy in one of two ways:
 - a. Submitting by June 1, 2018 to the BHO@omh.ny.gov mailbox, an RCA network adequacy proposal that contains the following:
 - Number of HARP enrollees;
 - Analysis of which SDE agencies have high numbers of HARP members currently accessing care (this can include programs within the agency such as: housing, OTP, clinic, ACT and/or PROS);
 - A plan to contract with SDEs and a written justification that these SDEs are sufficient in number and capacity to provide assessments, plans of care, and reassessments for their HARP membership; and
 - How the Plan will identify unassessed HARP members and connect them to a contracted RCA.
 - b. In the absence of a network adequacy proposal, the MCO must demonstrate they are contracted with fifty percent (50%) of SDEs in the MCO's catchment area by October 1, 2018.
2. HARPs must submit a RCA Network Contracting report to New York State on the status of their contracting relationships with RCAs. HARPs must maintain and make available to the State a list of all in-network contracted RCAs (by Agency/County). The first report must be submitted to the bho@omh.ny.gov by **June 1, 2018**. After this date, reporting will be submitted monthly. HARPs must use the state-provided template (see attached contract reporting template) and submit the following information accordingly:
 - CMA/SDE Name
 - Medicaid ID
 - Taxpayer ID
 - Address
 - County Served
 - Contact Person (MCO or BHO contact, Director level)
 - Contact Phone
 - RCA Contracting Status
3. For each contracted RCA, track and report the following metrics to the State:
 - Number of referrals to the RCA
 - Number of unique HARP members that refused Health Home enrollment
 - Total number of NYS Eligibility Assessments completed

- Number of unique HARP members who received an assessment
- For those who received an assessment, number who were:
 - i. Found Not Eligible for BH HCBS
 - ii. Found Eligible and interested in referral to BH HCBS
 - iii. Found Eligible but refusing BH HCBS
- For those refusing BH HCBS, reasons why:
 - i. Chose to remain in a setting that is not home and community-based
 - ii. Felt BH HCBS will not help them reach their goals
 - iii. Receiving state plan services already meeting their needs
- Number of unique HARP members unable to complete an assessment
- Of those unable to complete an assessment, reason why:
 - i. Member declined to be assessed for BH HCBS
 - ii. Unable to locate member
 - iii. Other

In the future, MCOs will be given the ability to generate automated reports directly out of UAS-NY. Until such time these reports are live and further guidance is provided, the MCOs are asked to record all required information.

4. NYS will provide the following oversight for RCA network adequacy:
 - a. NYS will monitor the number of assessments and reassessments completed for the MCO’s HARP membership;
 - b. The State has set a tentative benchmark of twenty percent (20%) of Non-HH enrolled individuals assessed for HCBS eligibility or declined assessment by October 2018;
 - c. NYS will consult with MCOs on a regular basis and at the mid-point of the assessment period may readjust the target as necessary; and
 - d. If the assessment benchmark is not met, the State will examine the adequacy of that HARP/HIV SNP’s SDE network and potentially require additional contract capacity.

VII. Reimbursement for Recovery Coordination Agency activities:

Rates³ for the NYS Eligibility Assessment and HARP HCBS Plan of Care development for HARP members that are not currently enrolled in a Health Home, or that have opted out of Health Home services are as follows:

Rate Code	Rate Code Description	Unit Measure	Upstate Rate*	Downstate Rate*
7778	HARP HCBS Assessment (“NYS	Per diem, can only be	\$71.33	\$80.00

³ Rates for these services are established pursuant to Chapter 57 of the Laws of New York of 2017.

	Eligibility Assessment")	billed 3 times per 365 days.		
7780	Plan of Care Development – Initial	None, code 1 unit	\$289.77	\$325.00
7781	Plan of Care Development – Ongoing	Per 15 min, no more than 8 15-minute increments per day	\$16.49	\$18.50

**There are no Plan administration fees associated with these rates.*

Claims for HARP HCBS assessments (rate code 7778) must be submitted directly to a Medicaid Managed Care Organization (MMCO). This would be the MMCO the RCA is contracted with and in which the assessed client is enrolled.

The “Plan of Care Development-Initial” rate code (7780) may be billed for a maximum of one time per year, for the development of the initial plan of care with the HARP Enrollee. Development of the plan of care includes requesting Level of Service Determinations, selection of providers, coordination of referrals to BH HCBS providers, and completion of the HCBS POC meeting all federal requirements, including scope, duration and frequency of BH HCBS.

When subsequent changes are needed to the Plan of Care (after the initial plan is developed and billed for as described above), rate code 7781 “Plan of Care Development-Ongoing” may be used. The POC shall be updated to reflect changes in the individual’s needs, goals, BH HCBS eligibility, and/or services needed. The Recovery Coordinator should document the work completed for the Plan of Care Development- Ongoing in increments of 15 minutes. Activities supported by this rate includes: requests for additional BH HCBS, selection of providers, and coordination of referrals to BH HCBS providers, and subsequent updates to the HCBS POC.

HARP HCBS Provider Travel Supplement (Transportation rates) may be used as needed to support assessment and/or plan of care (initial and ongoing) development. Rates for the travel supplements are as follows:

Rate Code	Rate Code Description	Unit Measure	Upstate Rate	Upstate Rate with MCO Admin	Downstate Rate	Downstate Rate with MCO Admin
7806	HARP HCBS Provider Travel Supplement (per mile)	Per mile	\$.52	\$.56	\$.58	\$.62

7807	HARP HCBS Provider Travel Supplement (subway, bus, taxi)	Per round trip	\$4.90	\$5.26	\$5.50	\$5.90
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Claims for Plan of Care Development, Initial and On-going (rate codes 7780 and 7781), as well as the travel supplement claims (rate codes 7806 and 7807) must also be submitted to the appropriate managed care plan.

All claims require the use of the 837i claim form and the use of rate codes.

Additional information regarding claim submission and fee schedules can be found [here](#).

If you have any questions regarding this guidance document, please contact the [OMH Managed Care mailbox](#).