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

**Subject: Guidance 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.

**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.

Each HARP/HIV SNP must contract with a sufficient number of SDEs to meet the HARP member need for HCBS assessments in each county. An adequate network shall contain, at a minimum, the greater of 50 percent of all the eligible SDEs in a county or two. In counties where there are not two eligible SDE providers, the plan must provide access to SDE in compliance with time and distance standards Section 15.5 of the Model Contract. If a HARP/HIV SNP would like to work with a provider agency not contained in the list by the State, the HARP should contact the State for review of the agency’s status.

**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 eligible SDEs.

SDE assessors 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).

**II. SDE Assessors must meet the NYS Adult BH HCBS Assessor qualifications:**

**Education and/or State Licensure/Certification**

- a. A bachelor's degree in one of the qualifying education fields<sup>1</sup>; or
- b. A NYS teacher's certificate for which a bachelor's degree is required; or
- c. NYS licensure and registration as a Registered Nurse and a bachelor's degree; or
- d. A Bachelor's level education or higher in any field with five years of experience working directly with persons with behavioral health diagnoses; or
- e. A Credentialed Alcoholism and Substance Abuse Counselor (CASAC).

AND

**Experience**

Two years of experience:

- a. Providing direct services to people with Serious Mental Illness (SMI), developmental disabilities, or substance use disorders (SUD); or
- b. Linking individuals with Serious Mental Illness, developmental disabilities, or substance use disorders 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).

A master's degree in one of the qualifying education fields<sup>1</sup> may be substituted for one year of Experience.

AND

**Supervision**

Supervision from a:

- a. Licensed healthcare professional with prior experience in a behavioral health clinical or care management supervisory capacity; or
- b. Master's level professional with 3 years' prior experience supervising clinicians and/or care managers who are providing direct services to individuals with SMI or SUDs.

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

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<sup>1</sup> Qualifying education includes 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.

- c. Additional training as required by the State.

**III. HARPs and HIV SNPs may contract directly with State Designated Entities (SDEs) for the following:**

**Assessment:**

- Conduct the NYS BH HCBS 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
- Submit the Level of Service Determination Request to the MCO
- 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. SDEs shall adhere to the following protocols:**

1. As part of the contractual agreement with the HARP or HIV SNP, SDEs must agree that assessors 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 interested (and with the member's consent), refer to or upward enroll the member in the Health Home.
2. Notifying the MCO when an individual is referred to an SDE by an individual or entity other than the individual's MCO. The SDE must notify the MCO prior to beginning assessment and care planning. The MCO will ensure the individual is not working with another SDE.
3. Conduct the NYS Eligibility Assessment for Adult BH HCBS; All contracted SDE assessors 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). Assessors shall 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. For members who are eligible for and wish to access BH HCBS, submit Level of Service Determination Request(s) to the HARP/HIV SNP that includes:
  - 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 interested in participating.
6. SDEs 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 SDE 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 SDEs for the provision of assessment and care planning.
  - a. The HARP/HIV SNP shall offer Health Home enrollment when engaging a HARP member at any point of contact, 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 SDE 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 SDE. The SPOA will provide notification to the MCO of that member's interest and referral to the SDE.
3. Issue Level of Service Determinations consistent with the Adult BH HCBS Workflow.
4. Record all Level of Service Determination requests and outcomes (approved or denied).

5. Work with SDEs 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.
6. Review and respond to BH HCBS provider requests for authorization of BH HCBS, as outlined in the Adult BH HCBS Workflow.
7. Maintain the information received from the SDE and BH HCBS providers and 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.
8. Arrange for reassessment of BH HCBS eligibility as required.

## **VI. HARP/HIV SNP Reporting Requirements:**

1. HARPs must report to New York State on the status of their contracting relationships with SDEs. HARPs must maintain and make available to the State a list of all in-network contracted SDEs (by Agency/County). The first report must be submitted to the [bho@omh.ny.gov](mailto:bho@omh.ny.gov) by **February 12, 2018**. HARPs must use the state-provided template (see attached contract reporting template) and submit the following information accordingly:
  - a. CMA/SDE Name
  - b. Medicaid ID
  - c. Taxpayer ID
  - d. Address
  - e. County Served
  - f. Contact Person (MCO or BHO contact, Director level)
  - g. Contact Phone
  - h. CMA Contracting Status
2. For each contracted SDE, track and report the following metrics to the State:
  - a. Number of referrals to SDE
  - b. Number of unique HARP members SDE provided education about HH enrollment but member refused Health Home
  - c. Total number of NYS Eligibility Assessments completed
  - d. Number of unique HARP members who received an assessment
  - e. 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
  - f. 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
  - g. Number of unique HARP members unable to complete an assessment
  - h. 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. Until such time as these reports are live and further guidance is provided, the MCOs are asked to record all required information.

**VII. Reimbursement for State Designated Entity (SDE) activities:**

Rates<sup>2</sup> 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 Eligibility Assessment”)	Per diem, can only be billed 3 times per 365 days.	\$71.33	\$80.00
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 SDE is contracted with and 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.

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 SDE should document the work completed for the Plan of Care Development- Ongoing in increments of 15 minutes.

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:

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<sup>2</sup> Rates for these services are established pursuant to Chapter 57 of the Laws of New York of 2017.

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

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](#).