New York State: Health and Recovery Plan (HARP)
Adult Behavioral Health Home and Community Based Services (BH HCBS)
Provider Manual

New York State is pleased to release the Adult Behavioral Health Home and Community Based Services (BH HCBS) Manual that will be used as a basis to begin the BH HCBS designation process. Please note that this manual only includes Adult BH HCBS available to eligible individuals in Health and Recovery Plans (HARP) or HARP-eligible in HIV Special Needs Plans (SNPs). The BH HCBS included in this manual have been approved by CMS to be included in the HARP benefit package.

The BH HCBS manual describes the basic requirements for any entity that is interested in providing BH HCBS behavioral health services within New York's public behavioral health system. These entities may include:

- Behavioral health contracted and non-contracted providers, including those that provide rehabilitation, employment, community-based treatment, peer support, and crisis services;
- State entities providing behavioral health services, including mental health and/or substance use disorder services; or other organizations or clinicians that meet criteria;
- Hospitals providing specialized behavioral health services;
- Licensed/ Certified residential, inpatient and organizations providing mental health and/or substance use disorder clinical services; and
- Programs that are currently providing outreach, peer, vocational, or rehabilitative services to individuals with substance use disorders (SUD) that are funded through Alternatives to Incarceration, Ryan White Federal funding, or funding from Department of Health and Mental Hygiene, NYC Department of Health or the AIDS Institute.

The BH HCBS Manual includes information regarding services that are allowable and reimbursable as approved by CMS. This information, includes service definitions and service requirements reflective of documents that were developed in accordance with Medicaid policies and protocols and submitted for approval. A separate billing manual outlining the reimbursement rates and billing codes can be found here: https://www.omh.ny.gov/omhweb/bho/billing-services.html. Specifically, the BH HCBS Manual outlines the following:

1. Services Definitions & Descriptions
2. Provider Qualifications
3. Eligibility Criteria
4. Limitations/Exclusions
5. Allowed Modes of Delivery
6. Additional Service Criteria
7. Practitioner credentials for service provision
8. BH HCBS that may be provided together (BH HCBS clusters)
9. Sample attestation forms

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I. Introduction

The Centers for Medicare and Medicaid Services (CMS) has authorized various BH HCBS under their Medicaid waiver authority. BH HCBS were initially established in an effort to keep individuals out of hospitals, nursing homes or other institutions. Recipients had to be evaluated and assessed to meet an institutional level of care, i.e., they could be admitted to an institution if not for the availability of the BH HCBS waiver program.

Section 1915i of the Social Security Act was established as part of the Deficit Reduction Act of 2005. 1915i afforded States the opportunity to provide HCBS under the Medicaid State Plan without the requirement that Medicaid members need to meet the institutional level of care as they do in a 1915(c) HCBS Waiver. The intent is to allow and encourage states to use the flexibility of HCBS to develop a range of community based supports, rehabilitation and treatment services with effective oversight to assure quality. These services are designed to allow individuals to gain the motivation, functional skills and personal improvement to be fully integrated into communities. The 1915i option acknowledges that even though people with disabilities may not require an institutional level of care (e.g. hospital, nursing home) they may still be isolated and not fully integrated into society. This isolation and lack of integration may have been perpetuated by approaches to service delivery which cluster people with disabilities, and don't allow for flexible, individualized services or services which promote skill development and community supports to overcome the effects of certain disabilities or functional deficits, motivation and empowerment.

The CMS allows states to include the flexibility of 1915i state plan services in 1115 Research and Demonstration Waivers. New York State has chosen to include 1915i-like BH HCBS in its 1115 Waiver amendment for behavioral health. The inclusion of these BH HCBS will give NYS managed care provider networks and most importantly, enrollees in managed care, a new range of BH HCBS in their benefit package. These services are designed to help overcome the cognitive and functional effects of behavioral health disorders and help individuals with behavioral health conditions to live their lives fully integrated into all aspects of their community.

The addition of these services to the benefit package will also assist NYS to meet the requirements of the Americans with Disabilities Act and the Olmstead Law. The primary goal is to create a supportive and empowering environment for people with behavioral health conditions to live productive lives within our communities.

The CMS also requires state oversight to determine: that the assessment is comprehensive, the planning process is person-centered and addresses services and support needs in a manner that reflects individual preferences and goals, the services were actually provided, and the person is assessed at least annually or when there is a change in condition (e.g., loss of housing, inpatient admission, etc.) to appropriately reflect service needs. CMS also requires assurances which the state, managed care plans and providers must monitor and report on to assure people receiving BH HCBS are receiving the appropriate services.

On March 17, 2014 CMS issued the Final HCBS Rule that established, upon other provisions, conformity across HCBS authorities for person-centered planning and allowable settings. The rule states that HCBS can only be provided in settings which are considered integrated community settings. New York State is reviewing these rules to determine how this will be addressed in certain housing, residential and day programs.

A person receiving HCBS must be assessed using a validated comprehensive assessment tool to determine their treatment, rehabilitation and support needs. A comprehensive, person centered plan of care is then developed and the person is then connected to appropriate services. The care plan must be developed in a "conflict free" manner, meaning the person conducting the assessment and developing the plan of care cannot direct referrals for service only to their agency or network. The person must have choice

among available providers. New York State has CMS approved safeguards to insure that all conflict free requirements for the HCBS HARP benefit are met.

The provider manual describes these services in detail and the requirements for providers' participation. We look forward to working with managed care plans and provider networks to transform our system of care to one that supports rehabilitation and recovery from behavioral health conditions.

II. Values/Core Principles

The past 30 years have seen a transformation of the public behavioral health system. The State-operated adult psychiatric hospital census has declined from over 20,000 to under 2,900. Access to outpatient treatment, community supports, rehabilitation, and inpatient psychiatric services at general hospitals have expanded. More than 38,000 units of state supported community housing for people living with mental illness have been developed. These community based resources have created a safety net which has helped the mental health system to evolve from a primarily hospital focused system to one of community support. The emergence of the peer recovery and empowerment movement in the 1990s has stimulated the shift in focus from support to recovery. The legal system's expansion of civil rights to include people with mental illness, as part of Olmstead Legislation and Americans with Disabilities Act, has begun to move policy from the concept of least restrictive setting to full community inclusion.

In 2008, New York State initiated detox reform that reduced incentives for unnecessary hospital detox and began the process of building community and ambulatory access to withdrawal symptom management for SUD patients who do not require a hospital level of care for safely discontinuing the use of substances. OASAS initiated ancillary withdrawal services to allow for the management of mild to moderate withdrawal symptoms in outpatient and inpatient settings. The goal will include access to medically supervised withdrawal management in all levels of care for symptom management where there is very low risk of medical complications of withdrawal. SUD individuals will be able to access treatment in the lowest level of care necessary to support long-term recovery.

The development of Health and Recovery Plans (HARPs) is intended to promote significant improvements in the Behavioral Health System as we move into a recovery- based Managed Care delivery model. A recovery model of care emphasizes and supports a person's potential for recovery by optimizing quality of life and reducing symptoms of mental illness and substance use disorders through empowerment, choice, treatment, educational, employment, housing, and health and well-being goals. Recovery is generally seen in this approach as a personal journey rather than a set outcome, and one that may involve developing hope, a secure base and sense of self, supportive relationships, self-direction, social inclusion, and coping skills.

The Behavioral Health Home and Community Based Services (BH HCBS) provide opportunities for adult Medicaid beneficiaries with mental illness and/or substance use disorders to receive services in their own home or community. Implementation of BH HCBS will help to create an environment where managed care plans, service providers, plan members, families, and government partner to help members prevent and manage chronic health conditions and recover from serious mental illness and substance use disorders. The partnership will be based on these core principles:

Person-Centered Care: Services should reflect an individual's goals and emphasize shared decision-making approaches that empower members, provide choice, and minimize stigma. Services should be designed to optimally treat illness and emphasize wellness and attention to the persons overall well- being and full community inclusion.

Recovery-Oriented: Services should be provided based on the principle that all individuals have the capacity to recover from mental illness and/or substance use disorders. Specifically, services should support the acquisition of living, employment, and social skills and be offered in home and community-based settings that promote hope and encourage each person to establish an individual path towards recovery.

Integrated: Services should address both physical and behavioral health needs of individuals. Care coordination activities should be the foundation for care plans, along with efforts to foster individual responsibility for health awareness.

Data-Driven: Providers should use data to define outcomes, monitor performance, and promote health and well-being. Performance metrics should reflect a broad range of health and recovery indicators beyond those related to acute care.

Evidence-Based: Services should utilize evidence-based practices where appropriate and provide or enable continuing education activities to promote uptake of these practices.

Trauma-Informed: Trauma-informed services are based on an understanding of the vulnerabilities or triggers experienced by trauma survivors that may be exacerbated through traditional service delivery approaches so that these services and programs can be more supportive and avoid re-traumatization. All programs should engage all individuals with the assumption that trauma has occurred within their lives. (SAMHSA, 2014)

Peer-Supported: Peers will play an integral role in the delivery of services and the promotion of recovery principles.

Culturally Competent: Culturally competent services that contain a wide range of expertise in treating and assisting people with Serious Mental Illness (SMI) and Substance Use Disorder (SUD) in a manner responsive to cultural diversity.

Flexible and Mobile: Services should adapt to the specific and changing needs of each individual, using off-site community service delivery approaches along with therapeutic methods and recovery approaches which best suit each individual's needs. BH HCBS, where indicated, may be provided in home or off-site, including appropriate community settings such as where an individual works, attends school or socializes.

Inclusive of Social Network: The individual, and when appropriate, family members and other key members of the individual's social network are always invited to initial meetings, or any necessary meetings thereafter to mobilize support.

Coordination and Collaboration: These characteristics should guide all aspects of treatment and rehabilitation to support effective partnerships among the individual, family and other key natural supports and service providers.

III. Eligibility and Enrollment

HARP enrollment will be open to Medicaid beneficiaries age 21 and older with serious mental illness and/or substance use disorders. Individuals enrolled in HIV SNPs determined by the State to be HARP-eligible may also be eligible for BH HCBS. A detailed workflow of the adult BH HCBS plan of care approval process can be found in the Appendix.

Individuals identified as HARP eligible must be offered care management through State-designated Health Homes. An initial cohort of individuals have been identified as HARP eligible based on their utilization of behavioral health services. This cohort has been shared with Medicaid managed care plans for their members and with Health Homes to begin the process of engaging HARP eligible members in care management. Going forward, HARP eligible members will be identified by the State on an ongoing basis and shared with the HARPs, which will make assignments to Health Homes.

NYS is also developing a process in which individuals can be referred to HARPs. HARP members will be required to be assessed for BH HCBS eligibility using the NYS Community Mental Health Eligibility Assessment. The NYS Eligibility Assessment will determine if an individual is eligible for BH HCBS, and if eligible, eligibility for Tier 1 or Tier 2 BH HCBS. Tier I services include employment, education and peer supports services. Tier 2 includes the full array of BH HCBS. If BH HCBS eligibility is determined based on the initial assessment, then a full assessment, called the NYS Community Mental Health Assessment, will

be completed and a Plan of Care developed. Once completed, a Health Home Care Manager will work in collaboration with the individual and identify the BH HCBS that will be included in the Plan of Care. If the individual does not meet the functional need for BH HCBS through the NYS Eligibility Assessment, the Plan of Care cannot include BH HCBS. If an individual does not want HCBS services, the Health Home Care Manager should note this and not conduct the full NYS Community Mental Health Assessment. Re-assessment for BH HCBS eligibility will be conducted on an annual basis, or after a significant change in the member's condition such as an inpatient admission or a loss of housing. Health Homes will provide care management and will conduct assessments and develop Plans of Care for individuals for BH HCBS. Designated provider agencies will deliver the BH HCBS as described in this manual.

Adjustment Authority:
The state will notify CMS and the Public at least 60 days before exercising the option to modify needs-based eligibility criteria in accord with 1915 (i).

IV. Person-Centered Planning and Service Delivery

Based on an independent assessment of functioning and informed by the individual, the written Plan of Care must meet the following CMS requirements:

1. The Plan of Care must include services chosen by the individual to support independent community living in the setting of his or her own choice and must support integration in the community, including opportunities to seek employment, engage in community life, control personal resources, and to receive services within the community;
2. Include the individual's strengths, capacities, and preferences;
3. Be developed to include clinical and support needs that are indicated by the independent functional assessment;
4. Be comprised of goals and desired outcomes that are chosen by the individual;
5. Include services and supports (paid by Medicaid, natural supports and other community supports) that will enable the individual to meet the goals and outcomes identified in the Plan of Care;
6. Include frequency, duration, and scope of BH HCBS identified in the Plan of Care;
7. Identification of risk factors and barriers with strategies to overcome them, including individualized back-up plans;
8. Be written in a way that is clearly understandable by the individual;
9. Include the individual and the entity that is responsible for the oversight of the Plan of Care implementation, review of progress and need for modifications if desired outcomes are not being met or the individual's needs change;
10. Include individual attestation of choice of providers;
11. Include an informed consent of the individual in writing along with signatures of all individuals responsible for the plan implementation;
12. Be sent to all of the individuals and others involved in implementing and monitoring the Plan of Care; and
13. The Plan of Care should not include services that are duplicative, unnecessary or inappropriate.

For more information about the required elements for a Plan of Care including BH HCBS, please view the following documents:

- BH HCBS Plan of Care Federal Rules and Regulations checklist: http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/hcbs_fed_person_centered_planning_process.pdf
- BH HCBS Plan of Care template: http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/hcbs_poc_template.pdf

V. BH HCBS Provider Designation

HCBS provider designation confirms that an agency has attested to provide BH HCBS within the agency's scope of practice and consistent with the criteria articulated in the BH HCBS manual. Providers are only designated to provide the BH HCBS that are included within their application and approved by the state.

HCBS provider designation does not guarantee that your agency will gain business for these services, nor does it mandate your agency must provide the designated services.

BH HCBS Attestation and Application Process:
The provider Attestation is an executive declaration that a provider meets the requirements to provide BH HCBS. Only one attestation form is necessary per agency, regardless of the number of services or site locations an agency plans to provide BH HCBS. Applicants must complete the site location, staffing, and written statement sections for each service you intend to provide. The application is designed for providers to demonstrate that they have the organizational capacity and culture to provide one or more of the BH HCBS. Applications will be reviewed based on an Agency's staff qualifications, experience, and ability to meet HCBS criteria.

The initial deadlines for applications included December 2014 for New York City and September 2015 for the rest of State. Applications received after December 2015 will be reviewed by NYS OMH and OASAS periodically for designation of intended services. More information regarding Provider Designation and the application process can be found at the following links:

- BH HCBS Provider Designation: https://www.omh.ny.gov/omhweb/bho/provider-designation.html
- BHHCBS Application for Provider Designation: https://www.omh.ny.gov/omhweb/bho/app-site.html

VI. BH HCBS Definitions

Psychosocial Rehabilitation (PSR)

Definition

PSR services are designed to assist the individual with compensating for or eliminating functional deficits and interpersonal and/or environmental barriers associated with their behavioral health condition (i.e., SUD and/or mental health). Activities included must be intended to achieve the identified goals or objectives as set forth in the individual's Service Plan. The intent of PSR is to restore the individual's functional level to the fullest possible (i.e., enhancing SUD resilience factors) and as necessary for integration of the individual as an active and productive member of his or her family, community, and/or culture with the least amount of ongoing professional intervention.

Service Components

This service may include the following components:

- Rehabilitation counseling including recovery-oriented activities and interventions that support and restore social and interpersonal skills necessary to increase or sustain community tenure, enhance interpersonal skills, establish support networks, increase community awareness, develop coping strategies and effective functioning in the individual's social environment such as home, work, and school including:
    - Independent Living: A close working relationship between staff and participant to develop and strengthen the individual's independent community living skills and support community integration
    - Social: Establishing and sustaining friendships and a supportive recovery social network, developing conversation skills and a positive sense of self; coaching on interpersonal skills and communication; training on social etiquette; relapse prevention skills; identify trauma triggers; develop anger management skills; engender civic duty and volunteerism
    - Community: Support the identification and pursuit of personal interests (e.g. creative arts, reading, exercise, faith-based pursuits, cultural exploration); identify resources where these interests can be enhanced and shared with others in the community; identify and connect with natural supports and recovery resources, including family, community networks, and faith-based communities
- Rehabilitation, counseling, recovery activities, interventions and support with skills necessary for the individual to improve self-management of and reduce relapse to substance use, the negative effects of psychiatric , or emotional symptoms, that interfere with a person's daily living, and daily living skills that are critical to remaining in home, school, work, and community.

Rehabilitation counseling and support necessary for the individual to implement learned skills so the person can remain in a natural community location including:

- Personal autonomy: Learning to manage stress, unexpected daily events and disruptions, mental health symptoms, relapse triggers and cravings with confidence; develop and pursue leisure and recreational interests, manage free time comfortably; transportation navigation
- Health: Developing constructive and comfortable interactions with health-care professionals, Relapse Prevention Planning; managing chronic medical conditions, mental health symptoms and medications; establishing good health routines and practices
- Social Skills: Engaging with people respectfully, appropriate eye contact, conversation skills, listening skills and advocacy skills
- Wellness: meal planning, healthy shopping and meal preparation, nutrition awareness, exercise options
- Personal care: grooming, sustaining living environment, managing finances and other independent living skills

- Rehabilitation counseling including recovery activities, interventions and support necessary for the individual to implement learned skills so the person can remain in a natural community location
- Assisting the individual with effectively learning adaptive behaviors responding to or avoiding identified precursors such as cravings or triggers that result in relapse or functional impairments

Ongoing assessment of the individual's progress toward recovery, functional skill and impairment levels that is used to select PSR interventions and periodically assess their effectiveness in achieving goals.

Modality

PSR is a face-to-face intervention which may be provided 1:1 or in groups.

Setting

- Services must be offered in the setting best suited for desired outcomes, including home, or other community-based setting in compliance with Medicaid regulations and the Home and Community Based Settings Final Rule (see appendix). The setting may include programs that are peer driven/operated or peer informed and that provide opportunities for drop-in.
- Services may be provided individually or in a group setting and should utilize (with documentation) evidence-based practices in rehabilitation and recovery. All individual and group interventions should be driven by the goal and objectives identified in the Plan of Care.
- On or off site.

Admissions/Eligibility Criteria

An individual must have the desire and willingness to receive rehabilitation and recovery services as part of his or her individual service plan, with the goal of living their lives fully integrated in the community and, if applicable, to learn skills to support long-term recovery from substance use through independent living, social support, and improved social and emotional functioning.

Providers who did not apply for both PSR and Habilitation are encouraged to apply for both of these services. Programs without a joint designation will not be allowed to serve individuals having both a PSR and Habilitation goal on their Plan of Care.

Limitations/Exclusions

These services may complement, not duplicate, services aimed at supporting an individual to achieve an employment-related goal in their plan of care. The total combined hours for Psychosocial Rehabilitation, Community Psychiatric Support and Treatment, and Habilitation are limited to no more than a total of 500 hours in a calendar year.

Certification/Provider Qualifications

Providers of service may include unlicensed behavioral health staff (see appendix). Workers who provide PSR services should periodically report to a supervising professional staff on participants' progress toward the recovery and re-acquisition of skills.

Staffing Ratio/Case Limits

Staff to Member Ratio: 1:20.

Community Psychiatric Support and Treatment (CPST)

Definition

CPST includes time-limited goal-directed supports and solution-focused interventions intended to achieve identified person-centered goals or objectives as set forth in the individual's Plan of Care and CPST Individual Service Plan.

The following activities under CPST are designed to help individuals with serious mental illness to achieve stability and functional improvement in the following areas: daily living, finances, housing, education, employment, personal recovery and/or resilience, family and interpersonal relationships and community integration. CPST is designed to provide mobile treatment and rehabilitation services to individuals who have difficulty engaging in site- based programs who can benefit from off-site rehabilitation or who have not been previously engaged in services, including those who had only partially benefited from traditional treatment or might benefit from more active involvement of their family of choice in their treatment.

Service Components

The service may include the following components to meet the needs of the individuals with mental health and/or a substance use diagnosis:

- Assist the individual and family members or other collaterals[1] to identify strategies or treatment options associated with the individual's behavioral health disorder, with the goal of minimizing the negative effects of mental illness symptoms or emotional disturbances or associated environmental stressors which interfere with the individual's daily living, financial management, housing, academic and/or employment progress, personal recovery or resilience, family and/or interpersonal relationships, and community integration
- Provide individual and their family supportive counseling, solution-focused interventions, emotional and behavioral management, and problem behavior analysis with the individual, with the goal of assisting the individual with social, interpersonal, self-care, daily living, and independent living skills to restore stability, to support functional gains and to adapt to community living
- Facilitate participation in and utilization of strengths based planning and treatments which include assisting the individual and family members or other collaterals with identifying strengths and needs, resources, natural supports, and developing goals and objectives to utilize personal strengths, resources, and natural supports to address functional deficits associated with their mental illness
- Assist the individual with effectively responding to or avoiding identified precursors or triggers that would risk their remaining in a natural community location, including assisting the individual and family members or other collaterals with identifying a potential psychiatric or personal crisis, developing a crisis management plan and/or as appropriate, seeking other supports to restore stability and functioning

[1] A significant other or member of the HCBS recipient's family or household, academic, workplace or residential setting, who regularly interacts with the individual and is directly affected by, or has the capability of affecting, his or her condition.

- Provide ongoing rehabilitation support for individuals pursuing employment, housing, or education goals. Assist the individual with independent living skills to promote recovery and growth specific to managing their own home including managing their money, medications, and using community resources and other self-care requirements
- Implement interventions using evidence-based and best practice techniques, drawn from cognitive-behavioral therapy and other evidence-based psychotherapeutic interventions that ameliorate targeted symptoms and/or recover the person's capacity to cope with or prevent symptom interference with daily activities.

Modality

CPST is a face-to-face intervention with the individual, family or other collaterals provided on a 1:1 basis.

Setting

- Services must be offered in the setting best suited for desired outcomes, including home or other community-based setting.
- Off site

Admissions/Eligibility Criteria

CPST services are intended to help engage individuals with mental health and/or a substance use diagnosis who are unable to receive site-based care or who may benefit from community based services, including those who had only partially benefited from traditional treatment or might benefit from more active involvement of their family in their treatment. In addition, this service is intended for individuals who are being discharged from inpatient units, jail or prisons, and with a history of non-engagement in services; individuals who are transitioning from crisis services; and, for individuals who have disengaged from care.

Limitations/Exclusions

Community treatment for eligible individuals can continue as long as needed, within the limits, based on the individual's needs. The intent of this service is to eventually transfer the care to a place based clinical setting.

The total combined hours for CPST, Psychosocial Rehabilitation (PSR) and Habilitation are limited to no more than a total of 500 hours in a calendar year.

Certification/Provider Qualifications

- Agencies who have experience providing similar services should already have a license to provide treatment services (i.e., Clinics, PROS, Intensive Psychiatric Rehabilitation Treatment (IPRT), Partial Hospitalization, Comprehensive Psychiatric Emergency Programs (CPEP), or currently utilize an evidence based or best practice off-site treatment model using licensed professionals.
- Professional staff (see appendix) must provide this service.

Staffing Ratio/Case Limits

Decisions about how to balance caseloads will be left to the provider agencies as they see appropriate to ensuring quality of care and maintaining acceptable performance outcomes.

Habilitation

Definition

Habilitation services are provided on a 1:1 basis and are designed to assist individuals with a behavioral health diagnosis (i.e. SUD or mental health) in acquiring, retaining and improving skills such as communication, self-help, domestic, self-care, socialization, fine and gross motor skills, mobility, personal adjustment, relationship development, use of community resources and adaptive skills necessary to reside successfully in home and community-based settings.

These services assist individuals with developing skills necessary for community living and, if applicable, to continue the process of recovery from an SUD disorder. Services include things such as: instruction in accessing transportation, shopping and performing other necessary activities of community and civic life including self-advocacy, locating housing, working with landlords and roommates and budgeting. Services are designed to enable the participant to integrate full into the community and ensure recovery, health, welfare, safety and maximum independence of the participant.

Service Components

- Habilitation services may help individuals develop skills necessary for community living and recovery with ongoing assessment of individuals' functional status and development of rehabilitative goals, such as:
    - Instruction in accessing and using community resources such as transportation, translation, and communication assistance as identified as a need in the plan of care and services to assist the participant in shopping and performing other necessary activities of community and civic life, including self-advocacy; for example, coordinating and helping to secure TTY services, language bank services, or other adaptive equipment needs
    - Instruction in developing or sustaining financial stability and security (e.g., understanding budgets, managing money, and the right to manage their own money). Assistance in developing financial skills through instruction of budget development, money management skills, and self-direction with regards to managing own funds and relapse triggers. (Specifically, if a resident has a representative payee, one goal must be to develop skills to manage more independently)
    - Skill training and hands-on assistance of instrumental activities of daily living, including assistance with shopping, cooking, cleaning, and other necessary activities of community and civic living (voting, civic engagement via community activities, volunteerism)
    - Habilitation provide onsite modeling, training, and/or supervision to assist the participant in developing maximum independent functioning in community living activities. The on-site modeling, cueing, and /or instruction and support may assist participant in developing maximum independent problem-solving, interpersonal, communication, and coping skills, including relapse prevention planning, integration/adaptation to home/community, on-site symptom monitoring, and self -management of symptoms
    - Facilitation of family reunification through coordination of family services as applicable and self-advocacy instruction. The goal would be to facilitate communication with family members/natural supports to encourage the development of recovery support plans, i.e., medication compliance, ADL skills, and functional changes
    - Housing preservation and advocacy training, including assistance with developing positive landlord-tenant relationships, and accessing appropriate legal aid services if needed including skills to successfully live with roommates
    - Assistance with developing strategies and supportive interventions for avoiding the need for more intensive services such as inpatient detoxification, coordinating crisis services, and consulting with current service providers (including SUD providers, mental health providers, health care providers, family-friends-natural supports, parole-probation-drug courts, state vocational rehabilitation services and other stakeholders) to develop a plan for intervention
    - Assistance with increasing social opportunities and developing social support skills that ameliorate life stressors resulting from the individual's disability and promote health,

wellness and recovery. For example, helping an individual to connect to community-based organizations based on individuals' identified interests that are available to the public and promote recovery and social integration
- Instruction in self-advocacy skills including activities designed to facilitate participants' ability to access social service systems (health care, substance abuse, employment, vocational rehabilitation, entitlements/benefits, self-help groups) and other recovery-oriented systems of care are included
- Instruction in developing strategies to manage trauma induced behaviors and/or PTSD as per a Trauma Informed Assessment
- The cost of transportation provided by residential service providers to and from activities is included as a component within the rate of the residential service. Providers of residential services are responsible for the full range of transportation services needed by the individuals they serve to participate in services and activities specified in their recovery-oriented service plan. This includes transportation to and from recovery-oriented services and employment services, as applicable.

Modality

Habilitation is a face-to-face service that is delivered 1:1.

Setting

Habilitation may be delivered (on-site), or in the community (off-site). This service can be provided by the individual's provider of housing services.

Admissions/Eligibility Criteria

The Individual requires habilitation and onsite services that may include, but are not limited to: cognition (cognitive skills), functional status (ADLs), and recovery-oriented community support.

Providers who did not apply for both PSR and Habilitation are encouraged to apply for both of these services. Programs without a joint designation will not be allowed to serve individuals having both a PSR and Habilitation goal in their Plan of Care. The state will work with these programs to facilitate this process.

Limitations/Exclusions

The total combined hours for Psychosocial Rehabilitation, Community Psychiatric Support and Treatment and Habilitation are limited to no more than a total of 500 hours in a calendar year.

Time limited exceptions to this limit for individuals transitioning from institutions are permitted if prior authorized and found to be part of the cost-effective package of services provided to the individual compared to institutional care.

Certification/Provider Qualifications

Providers of service may include unlicensed behavioral health staff (see appendix). Workers who provide PSR services should periodically report to a supervising by a professional staff on participants' progress toward the recovery and re-acquisition of skills.

Staffing Ratio/Case Limits

- Staff ratio of 1:20 or less
- Supervisory ratio: 1:5 (1 supervisor to 5 Direct Care Staff).

Family Support and Training

Definition

Training and support necessary to facilitate engagement and active participation of the family in the treatment planning process and with the ongoing instruction and reinforcement of skills learned throughout the recovery process. This service is provided only at the request of the individual. A person-centered or person-directed, recovery oriented, trauma-informed approach to partnering with families and other supporters to provide emotional and information support, and to enhance their skills so that they can support the recovery of a family member with a substance use disorder/mental illness. The individual, his or her treatment team and family are all primary members of the recovery team.

For purposes of this service, "family" is defined as the persons who live with or provide care to a person served on the waiver and may include a parent, spouse, significant other, children, relatives, foster family, or in-laws. "Family" does not include individuals who are employed to care for the participant.

Training includes instruction about treatment regimens, elements, recovery support options, recovery concepts, and medication education specified in the Individual Service Plan and shall include updates, as necessary, to safely sustain the participant at home and in the community. All family support and training must be included in the individual's service plan and for the benefit of the Medicaid covered participant.

Service Components

Allowable activities include:

- Training on treatment regimens including elements such as: recovery support options, recovery concepts and medication education and use of equipment
- Assisting the family to provide a safe and supportive environment in the home and community for the individual (e.g., coping with various behavior challenges, understanding Substance use disorder, psychotherapy, and behavioral interventions)
- Facilitate family and friends support groups under the direction of a certified peer
- Provide family mediation and conflict resolution services
- Development and enhancement of the family's specific problem-solving skills, coping mechanisms, and strategies for the individual's symptom/behavior management and prevention of relapse. This includes providing tools on problem solving and coping skills and strategies
- Collaboration with the family and caregivers in order to develop positive interventions to address specific presenting issues and to develop and sustain healthy, stable relationships among all caregivers, including family members, in order to support the participant's recovery. Emphasis is placed on the acquisition of coping skills by building upon family strengths
- Assisting the family in the acquisition of knowledge and skills necessary to understand and address the specific needs of the Medicaid eligible individual in relation to their substance use disorder/mental illness and treatment
- Provide family with training/workshops on topics including recovery orientation and advocacy, psycho-education, person-centeredness, recovery orientation, trauma, psychosocial rehabilitation, crisis intervention and related tools and skills such as Individual recovery plans, WRAP, self-care, emotional validation, communication skills, boundaries, emotional regulation, relapse prevention, violence prevention and suicide
- Assisting the family in understanding various requirements of the waiver process, such as the individual service plan, crisis/safety plan and plan of care process; training on understanding the individual's diagnoses; understanding service options offered by service providers; and assisting with understanding policies, procedures and regulations that impact the individual with substance use disorder/mental illness concerns while living in the community (e.g., training on system navigation and Medicaid interaction with other individual-serving systems)
- Training on community integration and self-advocacy
- Training on behavioral intervention strategies (e.g., communication skills, relapse prevention, violence and suicide prevention, etc.)
- Training on mental health conditions, services and supports including providing benefits and entitlements counseling and providing skills and knowledge to parents with mental illness and

SUD on issues such as problems with Criminal Justice stakeholders, Child Protective Services, Housing entities, etc. Training and technical assistance on caring for medically fragile individuals including those with severe substance use disorder/ mental illness and chronic medical conditions.

Modality

This is a face-to-face service which may be provided 1:1 or in groups consisting of family members. Group size cannot exceed 16 individuals.

Setting

Onsite and where an individual lives and community locations such as where an individual works or socializes.

Admissions/Eligibility Criteria

- Individual assessed to need, and has a preference for family support and training services. All families and those in the individual's support network are eligible for this service at the discretion of the individual
- A release of information from the individual is always required to allow staff to contact significant people, except in cases of threat of injury or death

Limitations/Exclusions

The total combined hours for Family Support and Training are limited to no more than a total of 40 hours in a calendar year.

Certification/Provider Qualifications

Unlicensed staff (see appendix) may provide this service.

Staffing Ratio/Case Limits

- 1:15 for staff to individual ratio, and 1:16 for groups with family members..

Short-term Crisis Respite

Definition

Short-term Crisis Respite is a short-term care and intervention strategy for individuals who have a mental health or co-occurring diagnosis and are experiencing challenges in daily life that create risk for an escalation of symptoms that cannot be managed in the individual's home and community environment without onsite supports including:

- A mental health or co-occurring diagnosis and are experiencing challenges in daily life that create imminent risk for an escalation of symptoms and/or a loss of adult role functioning but who do not pose an imminent risk to the safety of themselves or others
- A challenging emotional crisis occurs which the individual is unable to manage without intensive assistance and support
- When there is an indication that an individual's symptoms are beginning to escalate

Referrals to Crisis Respite may come from the emergency room, the community, self-referrals, a treatment team, or as part of a step-down plan from an inpatient setting. Crisis respite is provided in site-based residential settings. Crisis Respite is not intended as a substitute for permanent housing arrangements.

Service Components

Components offered may include: peer support, either on site or as a wrap-around service during the respite stay, health and wellness coaching, relapse prevention planning, wellness activities, family support, conflict resolution, and other services as needed:

- Onsite peer support during the respite stay
- Working with existing treatment providers
- Health and wellness coaching
- Relaxation techniques to help reduce stress, anxiety, emerging panic or feelings of losing control
- Coordinating with primary care, Health Home or other BH providers (on-site or through referrals)
- Relapse Prevention planning
- Wellness activities
- Family support
- Conflict resolution
- Ongoing communication between the individual, crisis respite staff, natural supports, and the individuals' established mental health providers to assure collaboration and continuity in managing the crisis situation and identifying subsequent support and service systems
- Collaboration with the individual, BH providers, Health Home Care manager and natural supports to make recommendations for modifications to the recipients' plan of care and treatment.

At the conclusion of a Crisis Respite period, crisis respite staff, together with the individual and his or her established mental health providers, will make a determination as to the continuation of necessary care and make recommendations for modifications to the individual's Plan of Care.

Modality

Short-term Crisis Respite is a face-to-face service.

Setting

- Site-based residential settings will offer a supportive home-like environment with a maximum preferred capacity of 8-10 individuals (fewer in rural areas), preferably in single rooms.
- The setting must be code compliant.
- Staffed and open 24 hours a day, seven days a week when a resident is present.
- Residents should be allowed to leave and return as needed, maintaining employment and other daily activities to the extent possible.

To the greatest extent possible, guests will be encouraged to maintain contact with significant others, including family members, friends, and spouses. To facilitate this contact, guests may have visitors at any time that is convenient and practical for the guest as well as the operations of the crisis respite center.

Admissions/Eligibility Criteria

All individuals receiving this service must be experiencing a crisis, and be:

- Willing to voluntarily stay at a Crisis Respite
- Willing to be assessed by a treating professional including undergo a BH HCBS assessment
- Willing to authorize release of medical records by relevant treating providers
- Have a mental health or co-occurring diagnosis and are experiencing challenges in daily life that create imminent risk for an escalation of symptoms and/or a loss of adult role functioning but who do not pose an imminent risk to the safety of themselves or others

Exclusions:

- Diagnosis of dementia, organic brain disorder or TBI
- Those with an acute medical condition requiring higher level of care
- At imminent risk to self or others that requires higher level of care

- Displays symptoms indicative of active engagement in substance use manifested in a physical dependence or results in aggressive or destructive behavior
- Does not have permanent housing or is homeless
- Is not willing or able to respect and follow the guest agreement during his/her stay
- Is not willing to sign necessary registration documentation
- Is not willing to participate in the wellness process during his/her stay

Limitations/Exclusions

No longer than 1 week per episode, not to exceed a maximum of 21 days per year. Individual stays of greater than 72 hours require prior authorization. Individuals requiring crisis respite for longer periods may be evaluated on an individual basis and approved for greater length of stay based on medical necessity.

Certification/Provider Qualifications

Crisis Respite services may be delivered by peers or unlicensed staff (see appendix):

- Crisis Respite should have a Program Director (1 FTE) who will have 3-5 years of management experience working in a social service or related setting and will supervise Crisis Respite staff and coordinate the day-to-day activities associated with managing the Crisis Respite
- Peer Respite staff will have experience as a recipient of mental health services with a willingness to share personal, practical experience, knowledge, and first-hand insight to benefit program enrollees
- Peer Respite staff will possess the competency to meet requirements outlined in the job description, and will complete any relevant trainings within 90 days of employment. All Peer staff must be OMH or OASAS certified

Staffing Ratio/Case Limits

- There shall be a minimum of one staff person on-site for every four guests from 7 am to 8 pm.
- Between the hours of 8 pm and 7 am, there shall be a minimum of two staff on-site.
- The director or a designee shall be available at all times by cell phone.

Intensive Crisis Respite

Definition

Intensive Crisis Respite (ICR) is a short-term, residential care and clinical intervention strategy for individuals who are facing a behavioral health crisis, including individuals who are suicidal, express homicidal ideation, or have a mental health or co-occurring diagnosis and are experiencing acute escalation of mental health symptoms. In addition, the person must be able to contract for safety.

Individuals in need of ICR are at imminent risk for loss of functional abilities, and may raise safety concerns for themselves and others without this level of care. The immediate goal of ICR is to provide supports to help the individual stabilize and return to previous level of functioning or as a step-down from inpatient hospitalization.

Service Components

Services offered include:

- Comprehensive assessment including screening for physical health conditions
- Comprehensive risk assessment medication management
- Individual and group counseling
- Training in de-escalation strategies
- Relaxation techniques to help reduce stress, anxiety, panic or feelings of losing control
- Monitoring for high risk behavior
- Psychiatric evaluation for competency

- Linkage to resources and referrals to community-based mental health and substance abuse treatment
- Peer support
- Relapse prevention planning
- Wellness activities
- Family support
- Engagement of Natural Supports
- Conflict resolution

Ongoing communication between individuals receiving ICR, crisis respite staff, and the individuals' established mental health providers is necessary to assure collaboration and continuity in managing the crisis, as well as to identify effective subsequent support and service resources. At the conclusion of an Intensive Crisis Respite period, clinical staff, together with the individual, will make recommendations for modifications to the individual's Plan of Care.

Modality

Intensive Crisis Respite is a face-to-face intervention.

Setting

Individuals are encouraged to receive respite in the most integrated and cost-effective settings appropriate to meet their respite needs, preferably in a residential, community-based setting. Please refer to the appendix for BH HCBS settings requirements.

Admissions/Eligibility Criteria

- Individuals who may be a danger to self or others and are experiencing acute escalation of mental health symptoms and/or at imminent risk for loss of functional abilities, and raise safety concerns for themselves and others but can contract for safety.
- Experiencing symptoms beyond what can be managed in a short term crisis respite.
- Individual does not require inpatient admission or can be used as an alternative to inpatient admission if clinically indicated and person can contract for safety.

Limitations/Exclusions

- 7 days maximum
- Intensive Crisis Respite services include a limit of 21 days per year. Individuals requiring Intensive Crisis Respite for longer periods than those specified may be evaluated on an individual basis and approved for greater length of stay based on medical necessity.
- Have an acute medical condition requiring higher level of care.

Certification/Provider Qualifications

- Agency must possess a current license to provide crisis and/or treatment services (i.e. clinic, Comprehensive Psychiatric Emergency Programs (CPEP), Partial Hospital, PROS, Psychiatric Inpatient or have licensed professionals who have a minimum of 1 year of experience in delivering off-site crisis services including conducting psychiatric evaluations and providing treatment.
- Agency must demonstrate capacity for mobile crisis visits to be conducted by a minimum of 2 staff persons – one of whom must be a licensed clinician.
- This service will be provided by a multidisciplinary team of licensed, unlicensed and certified peer staff.

Staffing Ratio/Case Limits

- Adequate number of staff and an appropriate staff composition to carry out its goals and objectives as well as to ensure the continuous provision of sufficient ongoing and emergency supervision and treatment.
- Every ICR shall have at least one psychiatrist as primary medical coverage. Back-up coverage may be a physician who will consult with the psychiatrist. The psychiatrist or physician shall be on call 24-hours-a-day and will make daily rounds. Counties of less than 50,000 population may utilize a licensed physician for on-call activities and daily rounds as long as the physician has postgraduate training and experience in diagnosis and treatment of SMI and SUD
- At least one registered nurse shall be on duty 24-hours-a-day, 7-days-a-week when there is an individual in care.

- Staffing ratio:

Beds:	1-10	11-20
RNs	1	1
Mental Health Treatment Staff	1	2

Education Support Services

Definition

Education Support Services are provided to assist individuals with mental health or substance use disorders who want to start or return to school or formal training with a goal of achieving skills necessary to obtain employment. Education Support Services consist of special education and related services as defined in Sections (22) and (25) of the Individuals with Disabilities Education Improvement Act of 2004 (IDEA) (20 U.S.C. 1401 et seq.), to the extent to which they are not available under a program funded by IDEA or available for funding by the NYS Adult Career & Continuing Education Services Office of Vocational Rehabilitation (ACCES-VR) (The Vocational Rehabilitation component (ACCES-VR) encompasses many of the services that were previously part of Vocational and Educational Services for Individuals with Disabilities, or VESID).

Education Support Services may consist of general adult educational services such as applying for and attending community college, university or other college-level courses. Services may also include classes, vocational training, and tutoring to receive a Test Assessing Secondary Completion (TASC) diploma, as well as support to the individual to participate in an apprenticeship program.

Supported education may include the a component of motivational Interviewing to facilitate and engage the person in identifying their intrinsic motivation in order to activate the choice of going forward in an educational program to increase the opportunity to obtain a job of their choosing.

Individuals authorized for Education Support Services must relate to an employment goal or skill development documented in the service plan. Education Support Services must be specified in the service plan as necessary to enable the individual to integrate more fully into the community and to ensure the health, welfare and safety of the individual. Examples of these goals would include, but not be limited to: tutoring or formal classes to obtain a Test Assessing Secondary Completion (TASC) diploma, vocational training, apprenticeship program or formal classes to improve skills or knowledge in a chosen career, community college, university or any college-level courses or classes.

Ongoing supported education service components are conducted after an individual is successfully admitted to an educational program. Ongoing follow-along is support available for an indefinite period as needed by the participant to maintain their status as a registered student.

Service Components

Service components include:

- Providing support in a variety of educational settings, such as classroom and test-taking environments
- Serve as a resource clearinghouse for educational opportunities, tutoring, financial aid and other relevant educational supports and resources

- Provide linkages to education-related community resources including supports for learning and cognitive disabilities
- Assist with admission applications and registration
- Identify financial aid resources and assist with applications
- Assist with transitions and/or withdrawals from programs such as those resulting from mental health or substance abuse challenges, issues and medical conditions and other co-occurring disorders
- Orient individual to school settings, navigating the school system and student services particularly disability services
- Providing cognitive remediation services to improve executive functioning abilities such as attention, organizing, planning and working memory
- Conducting a needs assessment, based on employment goal to identify education/training requirements, personal strengths and necessary support services
- Evaluate educational/ career plan on an ongoing basis and revise as needed in response to individuals' needs and recovery process
- Assist with skill development including study skills, note taking, time and stress management and social skills in relation to mental health and SUD history and other related issues
- Providing advocacy support to obtain accommodations such as requesting extensions for assignments and different test-taking setting if needed for documented cognitive or learning disability
- Providing instruction on self-advocacy skills in relation to independent functioning in the educational environment

Modality

This is a face-to-face service that is provided 1:1.

Setting

Ideal setting is in the educational setting site, but may be provided on site or off site.

Admissions/Eligibility Criteria

Individuals who have been assessed to need Education Support Services and clearly stated interest in obtaining employment with the skills obtained.

Limitations/Exclusions

- The hours for supported education are limited to no more than a total of 250 hours per year
- Documentation is maintained in the file of each individual receiving this service that the service is not otherwise available under section 110 of the Rehabilitation Act of 1973 or the IDEA.
- Can only access this service if other appropriate state plan services are not available or appropriate.

Certification/Provider Qualifications

- Education Specialists should possess a BA, and two years of experience supporting individuals in pursuing education goals.
- A supervisor may be unlicensed (see appendix) and requires a minimum of a BA (preferably a Masters in Rehabilitation or a relevant field), a minimum of three years of relevant work experience preferably as an education specialist. All staff should have minimum of two years working in the behavioral health.
- Staff should have knowledge in the following areas: disability accommodations and assistive technology, financial aid, student loan default, SUD recovery resources on campus, etc.

Staffing Ratio/Case Limits

- Maximum caseload for a full-time education specialist is 20 individuals and proportional number for part-time staff.

Empowerment Services - Peer Supports

Definition

Peer Support services are peer-delivered services with a rehabilitation and recovery focus. They are designed to promote skills for coping with and managing behavioral health symptoms while facilitating the utilization of natural resources and the enhancement of recovery-oriented principles (e.g. hope and self-efficacy, and community living skills). Peer support uses trauma-informed, non-clinical assistance to achieve long-term recovery from a behavioral health disorder.

Activities included must be intended to achieve the identified goals or objectives as set forth in the individuals individualized service plan, which delineates specific goals that are flexibly tailored to the participant and attempt to utilize community and natural supports. The intent of these activities is to assist individuals in initiating recovery, maintaining recovery, and enhancing the quality of personal and family life in long-term recovery.

The structured, scheduled activities provided by this service emphasize the opportunity for peers to support each other in the restoration and expansion of the skills and strategies necessary to move forward in recovery. Individuals providing these services will do so through the paradigm of the shared personal experience of recovery.

Service Components

There are 6 categories of peer-support components. They include:

1. **Advocacy**:
    - Assistance seeking and obtaining benefits and entitlements, food, shelter, permanent housing
    - Assisting recipients in participating in shared decision making (e.g. MyPSYCKES)
    - Linkage to and systems navigation within behavioral health and allied human services systems to access appropriate care (e.g. Peer Bridgers)
    - Benefits advisement and planning
    - Development of psychiatric advance directives (PAD)
    - Assistance advocating for self-directed services

2. **Outreach and Engagement**:
    - Companionship and modeling of recovery lifestyle, including participation in recovery activities that might be beyond the scope of treatment providers (e.g., eating together at a restaurant, attending or participating in a sporting event, attending a social event such as a concert or recovery celebration event)
    - Raising the awareness of existing services, pathways to recovery and helping a person to remove barriers that exist for access to them
    - Interim visits with individuals after discharge from Hospital Emergency Rooms, Detox Units or Inpatient Psychiatric Units to facilitate community tenure and increased readiness while waiting for the first post-discharge visit with a community-based mental health provider, treatment provider or appropriate system of care

3. **Self-help tools:**
    - Assist selecting and utilizing self-directed recovery tools such as Relapse Prevention Planning
    - Assist selecting and utilizing the things that bring a sense of passion, purpose and meaning into his/her life and coaching the person as they identify barriers to engaging in these activities
    - Assist individuals to help connect to natural supports that enhance the quality and security of life
    - Connecting individuals to “warm lines”
    - Connections to self-help groups in the community

4. **Recovery Supports:**
    - Recovery education and coaching for individuals and their family members
    - One to one peer support
    - Person centered goal planning that incorporates life areas such as community connectedness, physical wellness, spirituality, employment, self-help

- Assisting with skills development that guides people towards a more independent life

5. **Transitional Supports:**
   - Bridging from Jail or prison to an individual's home (note: that peer supports while in Jail are not Medicaid reimbursable)
   - Bridging from institutions to an individual's home (note: that peer supports while in an institution are not Medicaid reimbursable)
   - Bridging from general hospitals to an individual's home
   - Bridging from an individual's home to the community

6. **Pre-crisis and Crisis Supports:**
   - Providing companionship when an individuals in an emergency room or crisis unit or preparing to be admitted to detox, residential or other service to deal with crisis
   - Providing peer support in the individual's home or in the community to support them before (or in) a crisis or relapse
   - Developing crisis diversion plans or relapse prevention plans

Modality

This is a face to face service that is provided 1:1.

Setting

Peer supports may be provided in a variety of setting including, outpatient settings and in the community, and respite programs. The majority of the contacts with the individual should be offsite in the community. Meeting at community locations such as may include: an individual's home, homeless shelters and soup kitchens for the purpose of opening up a dialogue. Note: Peer Support must be the individual's recovery plan.

Admissions/Eligibility Criteria

Peer support is voluntary, subject to periodic review of goals and based on medical necessity.

Limitations/Exclusions

Peer support services are limited to no more than a total of 500 hours in a calendar year. Individuals receiving SUD outpatient treatment may not receive Peer Supports, if they are receiving an OASAS state plan peer service.

Note: peer services while an individual is incarcerated or institutionalized are not Medicaid reimbursable. Time spent on the phone with individuals is not Medicaid reimbursable. The cost of admission to an event (i.e., sports event or concert) is not Medicaid reimbursable. Advocacy for community improvement (not specific to the Medicaid eligible individual) is not Medicaid reimbursable.

Certification/Provider Qualifications

Peer support providers must have a certification as of the following:
- OMH established Certified Peer Specialist
- OASAS Certified Peer Advocate

OMH and OASAS certification programs are separate. Though OMH uses the Academy of Peer Support for training that is NOT the certification program. OMH peers must be certified by The New York Peer Specialist Certification Board (http://nypeerspecialist.org/) The OMH certification has minimal training on SUD issues. Likewise, the OASAS process has minimal training on mental health issues. For this reason, best practice would be for a peer specialist to have the certification that aligns with the type of program that are working in. If the program is an SUD program, then they should have the OASAS certification. If it is a mental health program, then they should have the OMH certification. For those

working with the dually diagnosed population, it is recommended that they have both certifications to be fully prepared to serve the populations of that program.

Certified Peer Specialists are appropriately supervised treatment team members who will play an integral role in care planning including the crisis intervention or relapse prevention plan, treatment planning and the development of psychiatric advance directives (PAD). Training for Peer Specialists will be provided/contracted by OMH and OASAS and will focus on the principles and concepts of recovery, coping skills, and advocacy, the unique competencies needed to assist another individual based on the shared personal experience paradigm.

Supervision of peer support must be provided by Professional Staff.

Staffing Ratio/Case Limits

Maximum 1 FTE to 20 consumers.

Pre-vocational Services

Definition

Pre-vocational services are time-limited services that prepare an individual for paid or unpaid employment. This service specifically provides learning and work experiences where the individual with mental health and/or disabling substance use disorders can develop general, non-job-task-specific strengths and soft skills that that contribute to employability in competitive work environment as well as in the integrated community settings. Pre-vocational services occur over a defined period of time and with specific person centered goals to be developed and achieved, as determined by the individual and his/her employment specialist and support team and ongoing person-centered planning process as identified in the individual's person-centered Plan of Care, Pre-vocational services provide supports to individuals who need ongoing support to learn a new job and/or maintain a job in a competitive work environment or a self-employment arrangement. The outcome of this pre-vocational activity is documentation of the individual's stated career objective and a career plan used to guide individual employment support.

Service Components

Service components include:

- Teach concepts such as: work compliance, attendance, task completion, problem solving, and safety, and, if applicable, teach individuals how to identify obstacles to employment, obtain paperwork necessary for employment applications, and how to interact without the use of drugs with people who have not used drugs especially in the work place
- Coordinate scheduled activities outside of an individual's home that support acquisition, retention, or improvement in job-related skills related to self-care, sensory-motor development, daily living skills, communication community living, improved socialization and cognitive skills. This could include opening and maintaining a bank account for work-related direct deposit
- Gain work-related experience considered crucial for job placement (e.g., volunteer work, time-limited unpaid internship) and career development

Services do not include development of job specific skills.

Modality

Pre-vocational services are face-to-face services and are 1:1.

Setting

This service is generally provided at the program site, but also includes support at a work location where the individual may acquire work-related experience such as volunteering and internships in the community.

Admissions/Eligibility Criteria

Individuals must have a clear desire to work in competitive employment.

Limitations/Exclusions

The total combined hours (for pre-vocational services and transitional supported employment) are limited to no more than a total of 250 hours and a duration of 9 months of service in a calendar year.

For all employment supports services, documentation is maintained in the file of each individual receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.). Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses, such as the following:

- Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program
- Payments that are passed through to users of supported employment programs
- Payments for training that is not directly related to an individual's supported employment program

When Pre-vocational services are provided at a work site where individuals are competitively employed, payment is made only for the adaptations, supervision, and training required by individuals receiving services as a result of their disabilities but does not include payment for the supervisory activities rendered as a normal part of the business setting or work environment.

Certification/Provider Qualifications

- Employment Specialists may be unlicensed (see appendix) and should possess education and experience equivalent to an undergraduate degree in vocational services, disabilities services, business, personnel management, mental health or social services counseling.
- A supervisor requires a minimum of a BA (preferably a Masters in Rehabilitation or a behavioral health field) and a minimum of three years' relevant work experience preferably as an employment specialist in a rehab or SUD treatment setting and minimum 18 months of disability/employment case management experience.

Staffing Ratio/Case Limits

- Maximum caseload for a full-time employment specialist is 20 clients and respective proportions for part-time staff.
- The recommended program manager to staff ratio is 1:10.

Transitional Employment

Definition

This service is designed to strengthen the individual's work record and work skills toward the goal of achieving assisted or unassisted competitive employment at or above the minimum wage paid by the competitive sector employer. This service is provided, instead of intensive supported employment, only when the individual specifically chooses this service and may only be provided by clubhouse, psychosocial club program, OASAS recovery center, or agency previously in receipt of a BH HCBS designation for this service.

This service specifically provides learning and work experiences where the individual with behavioral health and/or substance use disorders can develop general, non-job-task-specific strengths and soft skills that contribute to employability in the competitive work environment in integrated community settings paying at or above minimum wage.

The outcome of this activity is documentation of the individual's stated career objective and a career plan used to guide individual employment support.

Service Components

Service components include:

- Provide time-limited employment and on-the-job training in one or more integrated employment settings as an integral part of the individual's vocational rehabilitation growth.
- Provide support to individuals to gain skills to enable transition to integrated, competitive employment
- Training activities provided in regular business, industry, and community settings
- Promote integration and interaction between individuals with and without disabilities in the workplace.
- Provide Transitional Employment supports during placement. This support includes: initial and ongoing employment planning and advancement, employment assessment not otherwise covered in the annual career planning, job placement, job development, negotiation with prospective employers, job analysis, training and systematic instruction, job coaching, benefits supports, training, and planning transportation
- Training or referral to a training program
- Plan transportation to and from work
- Encourage and improve motivation and self-confidence to work in competitive employment
- Teach Activities of Daily Living (ADL) skills specific to the Transitional Employment placement and may include but is not limited to appropriate dress, hygiene, walk, talk, and eye contact, money management, dealing with address outstanding warrants, and legal and criminal justice history, time management, and the collection of work related documentation and credentials
- Offer Services not specifically related to job skill training that enable the waiver participant to be successful in integrating into the job setting
- Provide on the job supports, to include:
    - On-site job training
    - Assisting the participant to develop natural supports in the workplace without the use of substances that support recovery.
    - Adopt an identity as a worker
    - Accept responsibility for decisions
    - Examine past work experiences for setbacks and successes.
    - Consider potential for transferability of skills
    - Coordinate with the individual to identify employers and subsequently coworkers, as necessary, who may be able to accommodate the individual in meeting employment expectations, to address work related and personal issues as they may arise

Modality

Transitional Employment is a face-to-face intervention that is provided 1:1.

Setting

Transitional Employment may only be provided by a clubhouse, psychosocial club program, OASAS recovery center, or agency previously in receipt of a BH HCBS designation for this service.

Admissions/Eligibility Criteria

- An individual must have made a clear decision to work in competitive employment in the community regardless of limited or unsuccessful work history, or present status of sobriety and/or abstinence.
- The basic tenet of Transitional Employment is that all individuals are capable of working in competitive employment in the community even without prior training and all individuals interested in employment should be given the opportunity.

Limitations/Exclusions

The total combined hours for pre-vocational and transitional supported employment) are limited to no more than a total of 250 hours and a duration of 9 months of service in a calendar year.

Additionally, Transitional Employment placements should be part-time and time-limited, usually 15-20 hrs/week from 6-9 months in duration.

For all employment supports services, documentation is maintained in the file of each individual receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.). Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses, such as the following:

- incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program,
- payments that are passed through to users of the state VR supported employment programs, and
- payments for training that is not directly related to an individual's supported employment program.

When employment support services are provided in a competitive and integrated work site where individuals without disabilities are employed, payment is made only for the adaptations, supervision, and training required by individuals who receive services as a result of their disabilities and does not include payment for the supervisory activities rendered as a normal part of the business setting.

Certification/Provider Qualifications

- Employment Specialists may be unlicensed (see appendix) and should possess education and experience equivalent to an undergraduate degree in vocational services, business, personnel management, disability, mental health or social services counseling.
- A program manager requires a minimum of a BA (preferably a Masters in Rehabilitation or a behavioral health field), a minimum of three years' relevant work experience working in a vocational rehabilitation or SUD treatment setting and include a minimum of 18 months of disability/employment case management experience.

Staffing Ratio/Case Limits

- Maximum caseload for a full-time employment specialist is 20 clients and respective proportions for part-time staff.
- The recommended program manager to staff ratio is 1:10.

Intensive Supported Employment (ISE)

Definition

ISE services that assist recovering individuals with MH/SUDs to obtain and keep competitive employment. These services consist of intensive supports that enable individuals to obtain and keep competitive employment at or above the minimum wage. This service uses evidence based principles of the Individual Placement and Support (IPS) model.

This service is based on Individual Placement Support (IPS) model which is an evidence based practice of supported employment. It consists of intensive employment supports that enable individuals for whom competitive employment at or above the minimum wage is unlikely, absent the provision of supports, and who, because of their clinical and functional needs, require supports to perform in a regular work setting.

Individual employment support services are individualized, person-centered services that provide supports to individuals who need ongoing support to learn a new job and maintain a job in a competitive

employment or self-employment arrangement. Individuals in a competitive employment arrangement receiving Individual Employment Support Services are compensated at or above the minimum wage and receive not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. The outcome of this activity is documentation of the individual's stated career objective and a career plan used to guide individual employment support.

Service Components

Components include:

- Assist the individual to locate a job or develop a job on behalf of the individual via the use of individualized placement and support services that include rapid job search including acquisition of hard and soft skills to retain employment, training and systematic instruction, as well as providing support for the job application process such as resume writing, interviewing and application submission
- Support the individual to establish or maintain self-employment, including home-based self-employment
- Provide ongoing job related discovery and assessment

Provide job placement, systematic job development, job coaching, negotiation with prospective employers, job analysis, job carving (creating, modifying, or customizing a community-based job such that it can be successfully performed by an individual on supported employment), customize employment training and systematic instruction, benefits counseling support, training and planning, transportation, asset development and career advancement services, customized employment, and other workforce support services. Workforce support services include benefits counseling support (e.g., personalized benefits counseling that assists individuals in obtaining personalized information about their government entitlements), training and planning, transportation navigation, asset development and career advancement services.

Modality

Intensive Supported Employment is a face-to-face intervention and is provided 1:1.

Setting

This service is generally, based on individual need, provided at an employment program but can also be provided at a location of the individual's choosing that may include the workplace.

Admissions/Eligibility Criteria

- In order to achieve a successful outcome in ISE, an individual must have made a clear decision to work in competitive employment in the community.
- The basic tenet of ISE is that all individuals are capable of working in competitive employment in the community even without prior training and all individuals interested in employment should be given the opportunity.
- The ongoing level of care criteria including service duration, intensity and effectiveness should be reviewed by the BH HCBS provider and/or the MCO at least quarterly.

Limitations/Exclusions

250 hours per calendar year.

For all employment supports services, documentation is maintained in the file of each individual receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.). Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses, such as the following:

- incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program,

- payments that are passed through to users of supported employment programs,
- and payments for training that is not directly related to an individual's supported employment program.

When employment support services are provided at an integrated work site where individuals without disabilities are employed, payment is made only for the adaptations, supervision, and training required by OMH participants who receive services as a result of their disabilities but does not include payment for the supervisory activities rendered in as a normal part of the regular business setting.

Certification/Provider Qualifications

- Employment Specialists may be unlicensed (see appendix) and should possess education and experience equivalent to an undergraduate degree in vocational services, business, personnel management, disability, mental health or social services counseling.
- A supervisor requires a minimum of a BA (preferably a Masters in a behavioral health field) and a minimum of three years' relevant work experience preferably as an employment specialist or in a behavioral health treatment setting~~,~~ and includes a minimum 18 months of disability/employment experience.

Staffing Ratio/Case Limits

- Maximum caseload for a full-time employment specialist is 20 clients and respective proportions for part-time staff.
- The recommended program manager to staff ratio is 1:10.

Ongoing Supported Employment

Definition

This service is provided after an individual successfully obtains and becomes oriented to competitive and integrated employment.

Ongoing follow-along support is available for an indefinite period as needed by the individual to maintain their paid competitive employment position. Individual employment support services are individualized, person centered services providing supports to individuals who need ongoing support to learn a new job and maintain a job in a competitive employment or self-employment arrangement. Individuals in a competitive employment arrangement receiving Individual Employment Support Services are compensated at or above the minimum wage and receive not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by other individuals without disabilities.

Service Components

Service components include:

- Provide support in a variety of settings, particularly work sites where individuals with and without disabilities are employed:
    - Assists individuals to determine identify reasonable accommodations necessary to manage MH mental health symptoms or SUD triggers that may emerge at work
    - Provides activities needed to retain paid work including job coaching and non-work task related training
    - Ongoing Supported Employment services may include assessment of issues and linkage/referral to other recovery oriented community resources as appropriate
- Provide activities needed to sustain paid work by individuals, including supervision and training:
    - Provides supports to individuals who are currently employed in settings that are competitive and integrated
    - Assists individuals to establish positive workplace relationships, including interactions with supervisors, and co-workers

    - Helps individuals to build and sustain skills in the workplace, including time management, co-worker relationships and/or interactions, understanding supervisory roles and expectations, and accessing workplace supports, including EAP and job training for career advancement
- Providing reminders of effective workplace practices and reinforcement of recovery skills gained during the period of intensive supported employment services:
    - Assist individuals to manage behavioral health issues that may impact their recovery and ability to sustain long term employment.

The basic tenet of ISE is that all individuals are capable of working in competitive employment in the community even without prior training and all individuals interested in employment should be given the opportunity to work.

Modality

Ongoing Supported Employment is a face-to-face intervention and is provided 1:1.

Setting

Ongoing Supported Employment services may be provided in any community location as well as at the workplace. Its primary focus is to support individuals to manage behavioral health disorders in a manner that will not jeopardize their employment.

Focus and delivery of Ongoing Supported Employment may not duplicate vocational services for which the person is eligible through Rehabilitation Services Act (RSA/ACCES-VR).

Admissions/Eligibility Criteria

Must have made a clear goal to maintain employment in work in a competitive work environment employment located in the community.

Limitations/Exclusions

250 hours per calendar year.

For all employment supports services, documentation is maintained in the file of each individual receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.). Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses, such as the following:

- incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program,
- payments that are passed through to users of supported employment programs, and
- payments for training that is not directly related to an individual's supported employment program.

When employment support services are provided at a work site where individuals without disabilities are employed, payment is made only for the adaptations, supervision, and training required by participants receiving services as a result of their disabilities but does not include payment for the supervisory activities rendered as a normal part of the business setting.

Certification/Provider Qualifications

- Employment Specialists may be unlicensed (see appendix) and should possess education and experience equivalent to an undergraduate degree in vocational services, business, personnel management, disability, mental health or social services counseling.

- A supervisor requires a minimum of a BA (preferably a Masters in a behavioral health field or vocational rehabilitation counseling) and a minimum of three years' relevant work experience preferably as an employment specialist or in a behavioral health treatment setting~~,~~ and a minimum 18 months of disability/employment experience.

Staffing Ratio/Case Limits

- Maximum caseload for a full-time employment specialist is 20 clients and respective proportions for part-time staff.
- The recommended program manager to staff ratio is 1:10.

VI. Appendix

A. BH HCBS Clusters:

Many of the BH HCBS are designed to be provided in clusters that promote recovery along a spectrum. The clusters include:

- Community Psychiatric Support and Treatment (CPST) and Psychosocial Rehabilitation (PSR)
- Crisis Services: Intensive Crisis Respite and Short-term Crisis Respite
- Employment Services: Pre-vocational, Transitional, Intensive Supported Employment, Ongoing Supported Employment
- Peer Supports and Family Support and Training may be used in conjunction with other BH HCBS
- PSR and Habilitation: Providers are encouraged to apply for both of these services. Providers without a joint designation will not be allowed to serve individuals having both a PSR and Habilitation goal on their Plan of Care. The State will work with these programs to facilitate this process.

B. BH HCBS Provider Competencies in Evidence Based Practices:

Professional staff, unlicensed staff and certified peers who provide BH HCBS are encouraged to become trained on the various evidence based practices (EBPs). Free modules on various EBPs are available on the Website of Columbia University's Center for Practice Innovation's website (CPI; http://practiceinnovations.org/). The New York State Office of Mental Health (OMH) and the Department of Psychiatry, Columbia University, established the Center for Practice Innovations at Columbia Psychiatry and New York State Psychiatric Institute in November, 2007, to promote the widespread use of evidence-based practices throughout New York State. CPI uses innovative approaches to build stakeholder collaborations, develop and maintain practitioners' expertise, build agency infrastructures that support implementing and sustaining evidence-based practices and direct staff competence. CPI is available to collaborate with agencies to increase the use of EBPs and improve staff clinical competencies.

CPI offers the following web-based training modules:

- Treating co-occurring mental health and substance use disorders (called "Focus on Integrated Treatment" or FIT)
- Assertive community treatment (ACT)
- Supported employment/education via individual placement and support (IPS)
- Wellness self-management (WSM)
- First episode psychosis (called OnTrackNY)
- Increasing the use of clozapine
- Suicide prevention
- Tobacco dependence treatment

CPI also offers programs training and other supports to help programs build capacity to implement evidence-based practices. These include:

- Online training modules using personal recovery stories, clinical vignettes, interactive exercises, frequent knowledge checks, and expert panel presentations to engage the learner (over 40 to date. As of January 31, 2014, 14,072 participants have completed 157,164 modules)
- Face-to-face training
- Interactive webinars
- Online resource library with practical tools
- Consultations (both in person and by telephone)

The Northeast Addiction Technology Center has many training resources for SUD BH HCBS providers on substance use disorders as well as on SUD evidence based practices and can be found at http://www.nattc.org/home/ .

C. Staffing Guidelines:

I. **Professional staff** means practitioners possessing a license or a permit from the New York State Education Department who are qualified by credentials, training, and experience to provide direct services related to the treatment of mental illness and substance use disorders and shall include the following:

a. ***Certified Rehabilitation Counselor (CRC)*** is certified with a national Certified Rehabilitation Counselor (CRC) designation by The Commission on Rehabilitation Counselor Certification (CRCC) that sets the standard for quality rehabilitation counseling services in the United States and Canada. All VR staff within the OASAS treatment provider system must adhere to the Code of Ethics set forth by the NYS Ethics Commission (http://www.nyintegrity.org/) and/ or the Commission on Rehabilitation Counselor Certification (CRCC) (www.crccertification.com)

b. ***Creative arts therapist*** is an individual who is currently licensed as a creative arts therapist by the New York State Education Department or possesses a creative arts therapist permit from the New York State Education Department.

c. ***Licensed practical nurse*** is an individual who is currently licensed as a licensed practical nurse by the New York State Education Department or possesses a licensed practical nurse permit from the New York State Education Department.

d. ***Licensed psychoanalyst*** is an individual who is currently licensed as a psychoanalyst by the New York State Education Department or possesses a permit from the New York State Education Department.

e. ***Licensed psychologist*** is an individual who is currently licensed as a psychologist by the New York State Education Department or possesses a permit from the New York State Education Department and who possesses a doctoral degree in psychology, or an individual who has obtained at least a master's degree in psychology who works in a federal, state, county or municipally operated clinic. Such master's degree level psychologists may use the title "psychologist," may be considered professional staff, but may not be assigned supervisory responsibility.

f. ***Marriage and family therapist*** is an individual who is currently licensed as a marriage and family therapist by the New York State Education Department or possesses a permit from the New York State Education Department.

g. ***Mental health counselor*** is an individual who is currently licensed as a mental health counselor by the New York State Education Department or possesses a permit from the New York State Education Department.

h. ***Nurse practitioner*** is an individual who is currently certified as a nurse practitioner by the New York State Education Department or possesses a permit from the New York State Education Department.

i. ***Nurse practitioner in psychiatry*** is an individual who is currently certified as a nurse practitioner with an approved specialty area of psychiatry (NPP) by the New York State Education Department or possesses a permit from the New York State Education Department.

j. ***Physician*** is an individual who is currently licensed as a physician by the New York State Education Department or possesses a permit from the New York State Education Department.

k. ***Physician assistant*** is an individual who is currently registered as a physician assistant by the New York State Education Department or possesses a permit from the New York State Education Department.

l. ***Psychiatrist*** is an individual who is currently licensed to practice medicine in New York State, who (i) is a diplomate of the American Board of Psychiatry and Neurology or is eligible to be certified by that Board, or (ii) is certified by the American Osteopathic Board of Neurology and Psychiatry or is eligible to be certified by that Board.

m. ***Registered professional nurse*** is an individual who is currently licensed as a registered professional nurse by the New York State Education Department or possesses a permit from the New York State Education Department.

n. ***Social worker*** is an individual who is either currently licensed as a licensed master social worker or as a licensed clinical social worker (LCSW) by the New York State Education Department, or possesses a permit from the New York State Education Department to practice and use the title of either licensed master social worker or licensed clinical social worker.

II. Unlicensed Staff:

a. Unlicensed staff must be at least 18 years of age and have a high school diploma or equivalent, and 1-3 years of relevant experience working with individuals with SUD disorders and/or SMI or a BA degree.

b. A Certified Peer Specialist/Certified Recovery Peer Advocate, or equivalently qualified by education in the human services field or a combination of work experience and education, with one year of education substituting for one year of experience. A LMHP or QHP shall be available at all times to provide supervision, back up, support and/or consultation.

Direct service staff should be appropriately licensed or credentialed, trained and experienced practitioners with appropriate skills for engaging family members; providing education about substance use disorder/mental illness and its treatment; possessing information on community resources; guidance on how to manage or cope with substance use disorder relapse, maladaptive behaviors; emotional support and counseling; crisis planning; and problem solving skills training.

III. Certified Peer:

a. OMH-certified Peer Specialist

b. OASAS-certified Recovery Peer Advocate

IV. State Credentialed Staff:

a. ***CASAC:*** Staff person who holds a credential by the Office of Alcohol and Substance Abuse as a Credentialed Alcohol and Substance Abuse Counselor.

b. ***CASAC-T:*** Staff person who holds a credential by the Office of Alcohol and Substance Abuse as a Credentialed Alcohol and Substance Abuse Counselor-in-training.

V. Other Credentialed Staff:

Certified Psychiatric Rehabilitation Practitioner (CPRP): Staff person who holds a credential from the Psychiatric Rehabilitation Association as a practitioner working within the adult mental health system.

D. BH HCBS Documentation & Quality Assurance Reviews

BH HCBS Documentation requirements for encounters:

- Name of consumer
- Type of service provided
- Date of service provided
- Location of service
- Duration of service, including start and end times
- Description of interventions to meet Plan of Care goals
- Outcome (s) or progress made toward goal achievement
- Follow up/ next steps
- Your name, qualifications, signature and date

Quality Assurance Reviews:

- Quality Assurance reviews and claims audits will be conducted by NYS or its designee, including Local Government Units, to ensure providers comply with the rules, regulations, and standards of the program, and may be conducted without prior notice.
- The Quality Assurance reviews will focus on program aspects, but may include technical requirements such as billing, claims, and other Medicaid program requirements.
- Managed care plans may also be developing protocols to oversee the provision of these services in their provider networks.

E. Guidance for Behavioral Health Home and Community Based (BH HCB) Non-Medical Transportation Services for Adults in HARPs and HARP Eligibles in SNPs

A Health and Recovery Plan (HARP) is a type of Medicaid Managed Care Plan designed to make community-based recovery-oriented services and supports available to a greater number of Medicaid Managed Care enrollees. HARPs will be offered to adults aged 21 and over having significant behavioral health needs and avail all of the physical health and pharmacy benefits available for New York State mainstream Medicaid Managed Care Plans, including behavioral health, Health Home and long term care services. In addition, based on the individual's specific needs as identified in their Plan of Care and approved by the HARP in which they enroll, the HARP enrollee may be eligible for an array of Behavioral Health Home and Community Based Services (BH HCBS). Individuals who meet the HARP eligibility criteria who are already enrolled in an HIV Special Needs Plan (SNP) may remain in their current plan and still receive the benefits of a HARP, including access to the same BH HCBS benefit package if they are eligible. The BH HCBS benefit package includes the following array of services:

- Psychosocial Rehabilitation;
- Community Psychiatric Support and Treatment;
- Habilitation;
- Family Support and Training;
- Education Support Services;
- Empowerment Services- Peer Supports;
- Non-Medical Transportation;
- Pre-vocational Services;
- Transitional Employment;
- Intensive Supported Employment;
- Ongoing Supported Employment;
- Short-term Crisis Respite; and
- Intensive Crisis Respite.

All BH HCBS are designed to enable participants to integrate more fully into the community and ensure the overall health, welfare and safety of the participant.

In order to receive BH HCBS, eligible participants must be assessed by the Health Home Care Manager using the New York State Community Health Mental Health Assessment tool. Each approved BH HCBS must be tied to a goal as indicated in the Plan of Care, along with the duration and frequency of the needed service.

Definition of Non-Medical Transportation

Non-Medical Transportation services are offered, in addition to any medical transportation furnished under the 42 CFR 440.17(a) in the State Plan. Non-medical Transportation services are available for individuals to access authorized behavioral health home and community based services and destinations that are related to a goal included on the individual's plan of care.

Examples where this service may be requested include transportation to: HCBS that an individual was determined eligible to receive, a job interview, college fair, a wellness seminar, a GED preparatory class, etc.
This service will be provided to meet the participant's needs as determined by an assessment performed in accordance with Department requirements and as outlined in the participant's plan of care.

There is a $2,000 cost cap per participant per year for Non-Medical Transportation for trips to and from non-HCBS destinations that are related to goals in an individual's Plan of Care. Trips to and from BH HCBS and trips using public transportation are not subject to the $2,000 cap.

Roles Related to a Participant's Access to Non-Medical Transportation

The following roles and guidelines serve to inform the Health Home Care Manager, Managed Care Organization (MCO), and the Transportation Manager of the procedures and rules surrounding an eligible participant's access to the Non-Medical Transportation benefit.

Health Home Care Manager Roles
Health Home Care Managers are responsible for conducting the New York State Community Mental Health Assessment and developing the Person-Centered Plan of Care. If the care manager determines there is a need for transportation to support an individual's identified goals, the Health Home Care Manager will include justification for this service within the Person-Centered Plan of Care. The Health Home Care Manager will complete the "NYS BH HCBS Plan for Transportation Grid" (Grid)[2]. After completing the Plan of Care and the Grid, the Health Home Care Manager will send it to the MCO.

Managed Care Organization (MCO) Roles
The MCO is responsible for approving the Person-Centered Plan of Care and for forwarding the completed Grid to the Transportation Manager. For individuals not enrolled in a Health Home, the MCO will be responsible for completing the Grid based on the individual's Plan of Care and forwarding to the Transportation Manager. The Grid will include documentation for Non-Medical Transportation including documentation of which goals in an individual's Plan of Care the trips will be tied to.

The "NYS BH HCBS Plan for Transportation Grid" is completed by the MCO based on the participant's Plan of Care and includes the following information:

- Participant information;
- BH HCBS provider information;
- Non-Medical Transportation service requested;
- Supporting information includes:
    - Goal from the plan of care;
    - BH HCBS or Specific activity/support/task;
    - Mode of transportation service needed;
    - Trip destination/location;
    - Start date/end date; and

- Frequency.

The MCO will forward the completed Grid with the Transportation Manager any time there are changes to this Grid.

Transportation Manager Roles
The Transportation Manager is responsible for authorizing transportation services in accordance with Medicaid policy and as supported on the MCO-provided Grid. The Transportation Manager is responsible for ensuring adherence to the guidelines below for Non-Medical Transportation.

For each participant utilizing Non-Medical Transportation, the Transportation Manager will provide a monthly report of authorized trips to the State. The State will review the reports and inform the Transportation Manager when the $2,000 limit is approaching. The Transportation Manager will not authorize Non-Medical Transportation once they have been informed that the cost cap has been met.

Transportation Guidelines for Transportation Managers for Non-Medical Transportation

Generally, the same rules used to determine reimbursement of trips to medical appointments should be followed when considering reimbursement of non-medical trips for eligible participants.

The following guidelines apply to Non-Medical Transportation:

1. **Transportation must be tied to a goal in the Plan of Care.**
   Use of transportation to non-medical locations not typically covered for the Medicaid population may only be requested when such transportation is necessary to meet a goal identified in the participant's Plan of Care.

2. **Transportation is available for a specified duration and annual cost.**
   Non-Medical Transportation for trips to non-HCBS destinations tied to a goal in an participant's Plan of Care is limited to $2,000 per calendar year per participant and in duration as specified in the participant's Plan of Care. Trips to BH HCBS and trips using public transportation are not subject to the $2,000 cost cap. Non-Medical Transportation is intended to help initiate a new activity for a participant, rather than maintain an existing one. Non-Medical Transportation must be tied to a Plan of Care goal and is not available for routine events or ongoing treatment and services. An individual may use Non-Medical Transportation for reoccurring activities only if it is detailed in their Plan of Care; however the time frame and frequency for using Non-Medical Transportation in this capacity must be outlined. There must be an articulated frequency and start and end point for using Non-Medical Transportation to achieve a specific goal.

   The Transportation Manager will not authorize Non-Medical Transportation after they have been informed that the cost cap has been met. The State will inform the Transportation Manager when the limit is approaching.

3. **Individuals receiving residential services are ineligible for Non-Medical Transportation.**
   In order for individuals to access this benefit they must be assessed eligible for BH HCBS by the Health Home care manager. Individuals enrolled in residential services who receive transportation as part of the benefit are ineligible for Non-Medical Transportation.

4. **Use transportation available free of charge.**
   The first consideration prior to seeking Medicaid reimbursement for Non-Medical Transportation must be all informal supports, community services and public transit. When friends or family members are available to transport a participant, the friends or family members should be used to provide transportation. The individual friend or family member's name must be listed in the Plan of Care, and he or she must maintain a current New York State driver's license in good standing and drive an insured vehicle registered and licensed by New York State. It is expected that local travel to family events can be performed by one's family.

Transportation should be provided in the most cost effective way, and using the appropriate mode of transport. There may be some situations when the trip(s) costs are higher than average. Reimbursement for these trips will be considered on a case-by-case basis.

This service is not intended to replace services provided by ACCES-VR or any other existing vendor.

5. **Use the medically appropriate mode of transportation.**
   The same, appropriate mode of transportation used by the participant for standard medical trips should be used for non-medical trips, and vice versa.

   Any individual or company providing services as described in these Guidelines must maintain compliance with New York State regulations, including those in Title 18 NYCRR Section 505.10.

6. **Travel within the common marketing area.**
   Trips for the same or similar services should be within the same area that is frequented by others in the same community for those services as the participant.

7. **When possible, trips should be combined.**
   It is reasonable to expect a participant to complete non-routine needs tied to a goal in his or her Plan of Care in the same location if possible. Travel to multiple similar types of services on the same day and/or during the same week should be avoided.

8. **Justify need for travel outside the common marketing area.**
   Travel outside the common marketing area can be allowed when acceptable justification is presented.

9. **Vouchers submitted for personal vehicle mileage reimbursement must be submitted within 90 days of the date of service. Only when there are extenuating circumstances, will the Department allow payment for trips that are submitted after the 90 day time period. These requests will be considered on a case-by-case basis provided valid justification is given.**
   Requests for personal vehicle mileage reimbursement should be submitted on a timely, periodic basis concurrent with Department reimbursement policy guidelines. Personal vehicle mileage reimbursement for Non-Medical Transportation must be documented in the participant's Plan of Care and the Grid completed by the MCO to ensure that this transportation is tied to a participant's goal.

10. **Reimbursement for travel can be denied when the destination does not support the participant's integration into the community.**
    Absent adequate justification, travel to destinations such as casinos, "smoke shops", off-track betting parlors, adult entertainment businesses, hunting clubs, and pubs/bars will not be authorized. The participant can travel to these destinations; however, other community transportation supports should be used.

11. **The Transportation Manager/Prior Authorization Official should review the "NYS BH HCBS Plan for Transportation Grid" provided by the MCO only, not the participant's Plan of Care. The Prior Authorization Official should not monitor travel compliance with that Plan.**
    A participant's Plan of Care outlines the general parameters of his or her Non-Medical Transportation needs. However, these needs can change or be amended based upon the participant's stated goals and/or successful ongoing integration into the community.

    The MCO will complete the Grid based on the participant's Plan of Care and provide it to the Transportation Manager any time there are changes to the Grid. The Grid includes the following information:

    - Participant information;
    - BH HCBS provider information;
    - Non-Medical Transportation service requested;
    - Supporting documentation includes:
        - Goal from the plan of care;
        - Specific activity/support/task;

- Type of transportation service needed;
- Trip destination/location;
- Start date/end date; and
- Frequency.

The Transportation Manager/Prior Authorization Official will use the Grid coupled with Medicaid transportation policies to approve travel as appropriate. The Transportation Manager can request additional information from the Health Home Care Manager or MCO to assist with the decision to approve or disapprove Non-Medical Transportation reimbursement.

In addition to transportation to BH HCBS, examples of locations to which Non-Medical Transportation can be considered for eligible individuals include:

Goal in Plan of Care	Non-Medical Location to Which Transportation May Be Requested
Obtain Employment	Job interview
Go back to school	College fair
Owning a pet	Go to a shelter to adopt an animal
Losing weight	Attend a wellness seminar
Get involved in the arts	Attend a play
Improve personal hygiene	Go to a barber/beauty shop for a hair cut
Be more physically active	Attend a dance class
Obtain High School equivalency certification	Attend a workshop to prepare for the GED test

*All goals are to be met within a specific timeframe. Requests for transportation to a service associated with the goal that are submitted outside the specified timeframe will not be considered.

**Non-Medical Transportation cannot be used for routine transportation to and from a job or school. For example, a participant may be transported to a job interview, but not to work on a daily basis. Similarly, a participant may be transported to a college fair, but not to classes on a regular basis. The frequency of these trips should be included in the plan of care with a specific timeframe defined including a start and end date.

NYS Behavioral Health Home and Community Based Services (BH HCBS) Plan for Transportation Grid

1. Participant Information

Participant Name: _____ DOB: _____

Care Management Program: _____Medicaid ID: _____ Date of Plan: _____

Address _____ City _____ County _____ Zip code _____

2. MCO Information

MCO _____ Telephone _____ Fax _____

County _____ Address _____ City _____ State _____ Zip code _____

3. Transportation Provider Information

Transportation Provider _____ NPI _____ Telephone _____ Fax _____

County _____ Address _____ City _____ State _____ Zip code _____

Transportation Provider _____ NPI _____ Telephone _____ Fax _____

County _____ Address _____ City _____ State _____ Zip code _____

Transportation Provider _____ NPI _____ Telephone _____ Fax _____

County _____ Address _____ City _____ State _____ Zip code _____

4. Non-Medical Transportation

Goal (from Plan of Care)	BH HCBS or Specific Activity/ Support/ Task	Type of Transportation Service Needed	Trip Destination/ Location	Start Date/ End Date	Frequency	Non-HCBS Trip?*
						Y ☐ / N ☐
						Y ☐ / N ☐
						Y ☐ / N ☐

Date _____ Completed By_____ Telephone_____ Email_____ Fax_____

*Non-HCBS trips are subject to the $2,000 per year per participant cap for Non-Medical Transportation. Trips to BH HCBS and trips using public transportation will not apply to the cost cap.

F. BH HCBS Settings Overview

The CMS Final Rule (§441.301(c)(4) and §441.710) defines the qualities that all home and community-based settings must possess in order to be in compliance with the rule. In the final rule, CMS also clarifies which settings do NOT qualify as home and community based settings.

According to CMS, settings that **DO NOT MEET** the definition of being home and community based are:

- A nursing facility;
- An institution for mental diseases;
- An intermediate care facility for individuals with intellectual disabilities;
- A hospital; or
- Any other locations that have qualities of an institutional setting, as determined by the Secretary.

In addition, the final rule 441.301(c)(5)(v) specifies that the following settings Are **Presumed to Have the Qualities of an institution** (and therefore likely do not meet the HCBS standard without documentation to support otherwise):

- Any setting that is located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment,
- Any setting that is located in a building on the grounds of, or immediately adjacent to, a public institution, or
- Any other setting that has the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS.

CMS has created a **Settings Requirements Compliance Toolkit** that may be found here: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Home-and-Community-Based-Services/Home-and-Community-Based-Services.html

Included in the toolkit are **exploratory questions to assist in the assessment of residential settings**, found here: http://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/home-and-community-based-services/downloads/exploratory-questions-re-settings-characteristics.pdf

Additionally, there are **exploratory questions to assist in the assessment of non-residential settings**, found here: http://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/home-and-community-based-services/downloads/exploratory-questions-non-residential.pdf

Forthcoming, New York State will release a checklist for providers to use to establish compliance with the Final Rule regarding settings. We will disseminate.