New York State Section 1115 Behavioral Health Partnership Plan Waiver Amendment
December 30, 2013

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New York State Section BH 1115 Waiver Amendment

Introduction

As part of Governor Andrew Cuomo's efforts to "conduct a fundamental restructuring of (the) Medicaid program to achieve measurable improvement in health outcomes, sustainable cost control, and a more efficient administrative structure," the Governor appointed a Medicaid Redesign Team (MRT). The MRT created several work groups to review and provide recommendations in key areas, including behavioral health (BH). The BH work group was co-chaired by Linda Gibbs, the Deputy Mayor of New York City and Michael Hogan, the former Commissioner of the New York State Office of Mental Health (OMH). The 22 members of the work group included Commissioner Arlene González-Sánchez of the NYS Office of Alcoholism and Substance Abuse Services (OASAS), advocates, providers, insurers, and other stakeholders from the New York BH community. Through the work group's six meetings, a series of recommendations were adopted. The MRT adopted recommendations from its BH work group concerning the development of specialty BH managed care.

As a result of the robust public process, the State is submitting this amendment to its current 1115 demonstration to enable qualified managed care organizations (MCOs) throughout the State to comprehensively meet the needs of participants with BH needs. These needs will be met in the following ways:

- Mainstream MCOs: For all adults served in qualified mainstream MCOs throughout the State, the qualified MCO will integrate all Medicaid covered services for mental illness, substance use disorders (SUDs), and physical health (PH) conditions under this demonstration. Members enrolled in the Health and Recovery Plans described below will not be enrolled in mainstream (they are distinct benefits) but the same plan may offer both products.
- Health and Recovery Plans (HARPs): For adult populations meeting the serious mental illness (SMI) and SUD targeting criteria and risk factors, the State will enroll individuals in specialty lines of business within the qualified mainstream MCOs statewide. These distinct specialty lines of business will be called HARPs. Within the HARPs, an enhanced benefit package in addition to the State Plan services will be offered for enrolled individuals who meet both targeting and needs-based criteria for functional limitations. The needs based criteria are in addition to any targeting and risk factors required for HARP eligibility. The enhanced benefit package will help maintain participants in home and community-based settings. These enhanced benefit packages will be provided by the qualified full-benefit HARPs. The qualified HARP, contracting with Health Homes, will provide care management for all services including the 1915(i)-like services[1] in compliance with home and community-based standards and assurances.
- Children in Mainstream MCOs: Children's BH services, including all four home and community-based service (HCBS) waivers operated by OMH and the Office of Children and Family Services, will be included in the mainstream MCOs at a later date. An additional demonstration amendment may be necessary to provide further detail on the requirements for the children's behavioral health model.

[1] If access to a Health Home is not available, then Targeted Case Management (TCM) will be utilized for TCM qualified individuals to provide case management until such time as sufficient Health Home access exists and TCM is phased out.

The goals of the various managed care models and qualification process are to improve clinical and recovery outcomes for participants with SMI and/or SUDs; reduce the growth in costs through a reduction in unnecessary emergency and inpatient care; and increase network capacity to deliver community-based recovery-oriented services and supports. To ensure Managed Care Organizations (MCOs) are equipped to meet the needs of the behavioral health population, the plans will be reviewed and qualified against new behavioral health specific administrative, performance, and fiscal standards. Implementation will be staggered, according to the timeline later in this document.

Background

The MRT process started with the premise that New York's BH system (which provides specialty care and treatment for mental illness and SUD) is large and fragmented. In its report, the MRT BH Subcommittee discussed that the publicly-funded MH system alone serves over 600,000 people and accounts for about $7 billion in annual expenditures[2]. Approximately 50% of this spending goes to inpatient care. The publicly funded SUD treatment system serves over 250,000 individuals and accounts for about $1.7 billion in expenditures annually. Despite the significant spending on BH care, the system has historically offered little comprehensive care coordination even to the highest-need individuals, and there is insufficient accountability for the provision of quality care and for improved outcomes for patients/consumers.

The MRT report also documented that BH is not well integrated or effectively coordinated with PH care at the clinical level or at the regulatory and financing levels. The BH system is currently funded primarily through fee-for-service (FFS) Medicaid, while a substantial portion of PH care for people with mental illness or SUDs is financed and arranged through Medicaid Managed Care plans. This further contributes to fragmentation and lack of accountability. This lack of coordination extends well beyond PH care into the education, child welfare, and juvenile justice systems for those under the age of 21, as well as the homeless and forensic systems for adults.

When care is uncoordinated, there are greater risks that BH needs go unidentified and that consumers receive suboptimal BH care in primary care settings. Untreated or suboptimal treatment of BH conditions has long been associated with lower adherence to prescribed medical treatment, higher medical costs, and poorer health outcomes. In particular, adults with mental disorders have a "twofold to fourfold elevated risk of premature mortality", largely due to poorer PH status, as well as accidents or suicides.[3] There is emerging evidence of the effectiveness of interventions designed to address the need for BH/PH coordination. Given that for Medicaid's highest cost adult beneficiaries, approximately two-thirds have a mental illness and one-fifth have both a mental illness and SUD[4], the opportunity for improved clinical and financial outcomes through improved BH/PH coordination is strong.

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[2] This number includes funding from all payers.

[3] Druss, Benjamin and Reisinger Walker, Elizabeth. *Mental Disorder and Medical Comorbidity*, The Robert Wood Johnson Foundation, The Synthesis Project. February 2011.

[4] Boyd, Cynthia, Leff, Bruce, Weiss, Carols, Wolff, Jennifer, Hamblin, Allison and Martin, Lorie. *Clarifying Multimorbidity Patterns to Improve Targeting and Delivery of Clinical Services for Medicaid Populations*, Center for Health Care Strategies, Inc., December 2010.

Introducing managed care technologies through integrating BH and PH for SUD, SMI and non-SMI populations has been associated with improved access, better monitoring of quality outcomes and a better distribution of services across the entire care continuum.[5]

Based on the current managed care landscape in the State, the design of the State's BH Medicaid program will have three key operational components:

- Integration of all Medicaid BH and PH benefits under managed care, beginning with adults in New York City on January 1, 2015, adults in the rest of the State on July 1, 2015, and children statewide on January 1, 2016.
- Qualifying MCOs and HARPs prior to the implementation date to ensure adequate capabilities to manage BH services and supports. The qualification will include verifying the program and financial management structures to support the transition to, and ongoing operation of, the newly integrated BH/PH system and ensuring member continuity of care requirements from FFS to managed care.
- An integrated BH/PH premium and minimum medical loss ratio (MLR) for HARPs and a BH MLR for Qualifying MCOs. All BH capitation rates and Health Home reimbursement will flow through the Plans. Plans will be required to separately report BH expenditures to ensure improved access to new BH services and to work with Health Homes to ensure coordinated plans of care.

These components are designed to enable the State to achieve its MRT vision of:

- Improved access to appropriate BH and PH care services for individuals with mental illness or SUDs.
- Better management of total medical costs for individuals with co-occurring BH/PH conditions.
- Improved health outcomes and consumer satisfaction.
- Transformation of the BH system from one dominated by BH inpatient care to one dominated by community-based ambulatory care.
- Creation of a service delivery system that supports employment, success in school, housing stability and social integration.

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[5] Center for Health Care Strategies, Inc., *Integrating Medicaid Physical and Behavioral Health Services: Lessons from Pennsylvania*, www.chcs.org/publications3960/publications_show.htm?doc_id=1261427, accessed on June 11, 2013. "An independent evaluation of the two-year pilot efforts has identified significant impacts on cost and quality outcomes, and promising strategies that could be implemented in other states to promote integration."

Kim, Jung, Higgins, Tricia, Gerolamo, Angela, and Esposito, Dominick, Mathematical Policy Research, and Hamblin, Allison, CHCS,, May 2012.

Bella, Melanie, Somers, Stephen A., Llanos, Karen, CHCS, *Providing Behavioral Health Services to Medicaid Managed Care Enrollees: Options for Improving the Organization and Delivery of Services*, June 2009.

Institute of Medicine. *Improving the Quality of Health Care for Mental and Substance-Use Conditions*. Washington, DC: National Academy Press, 2006. World Health Organization. *Organization of Services for Mental Health*. Geneva: WHO, 2003.

The program design takes a multi-pronged approach to achieve this vision. The goal is raising the expectations and outcomes of BH management for all members. Key elements of the design include:

- Network requirements/enhancements to increase capacity and expand the service array to improve access to community-based services that facilitate recovery for adults and resiliency for children and are grounded in evidence-based practices.
- Clear expectations for management of the BH benefit that will increase expectations for quality management and improved member outcomes.
- Routine screening of participants in primary care settings to identify unmet BH needs, with expedited referrals to needed BH services.
- Routine screening of participants in BH settings to identify unmet medical needs, with expedited referrals to appropriate PH services.
- Data integration to support predictive modeling to identify high risk/high cost consumers and to facilitate program evaluation across systems.
- Utilization management (UM), medical management, and quality management (QM) protocols and other administrative services to ensure BH service delivery, and associated financial and clinical outcomes are appropriately managed.
    - DOH, in conjunction with OMH and OASAS, will pre-approve all MCO developed BH service criteria practice guidelines for utilization review, prior authorization, and level of care.
    - Each MCO must utilize an OASAS-approved SUD level of care tool for all SUD level of care decisions. This will include, but may not be limited to, New York's current LOCATDR tool.
- Specialized case management and care coordination protocols to improve consumer engagement, promote self-care, and enhance cross system coordination for high risk/high cost consumers, including participation in the Health Home innovations.
- Comprehensive and ongoing education, training and technical assistance programs for members, BH and PH providers, and MCO staff to facilitate transformation of the system.
- A transition plan, with key milestones and timelines for transitioning management of FFS services to the MCOs and implementing other key program components.
- Expansion of access to community-based BH services.

Because some MCOs may not have the expertise to manage specialty BH benefits, MCOs will need to demonstrate their qualifications, partner with experienced vendors or providers or subcontract with a BH organization that meets the qualifications.

Specialty BH Care for Special Populations

Improving BH/PH coordination requires effective managed care technologies that go beyond basic utilization review of higher levels of care to incorporate care management protocols for the populations with functional needs such as participants with SMI, SUD or serious emotional disturbance (SED). In addition, many participants who are not currently eligible for Medicaid receive critical BH services through State-only funds, federal block grant dollars or other resources. Many of the participants who have not historically been eligible for Medicaid become eligible for Medicaid under health care reform in 2014. Under this demonstration, the State plans

to develop a more integrated system of care with an eye toward meeting the BH needs of the Medicaid expansion population in 2014. At this time, the State anticipates offering newly eligibles the same benefits as current Medicaid eligibles.

The management of SMI and SUD populations, the use of medication to enhance treatment of SUDs, integration of PH, MH, and SUD services for SMI and SUD populations requires specialized expertise, tools, and protocols which are not consistently found within most medical plans. As a result, for adult populations meeting the SMI and SUD targeting and functional limitations statewide, specialty BH care will be provided by full-benefit HARPs.

Program Components

As noted above, there are essentially three aspects to this 1115 demonstration amendment:

- Inclusion of BH services for adults in the mainstream MCOs currently under the 1115 demonstration.
- Enrollment of participants meeting targeting criteria and risk factors in HARPs and expansion of BH HCBS supportive services to participants meeting targeting, risk factors, and needs-based criteria.

See Table 1 below for an explanation of the program initiatives.

Table 1: Program Description Initiatives by Geographic Area

Population	Geographic Area	Benefits	Delivery System
Adults not meeting HARP targeting and need criteria	Statewide	Medicaid State Plan benefits	Qualified mainstream MCOs
Adults with SMI and SUD meeting targeting criteria and risk factors	Statewide	Medicaid State Plan benefits 1915(i)-like services and supports (based on functional need)	HARPs which are separate lines of business in qualified mainstream MCOs

An amendment to the State's current 1115 demonstration is necessary. The State's current approved demonstration and its delivery system will be expanded to provide a robust continuum of BH care and to ensure that participants within MCOs with BH needs are fully supported in community living arrangements. There is simultaneously a Medicaid State Plan Amendment that will be submitted to the Centers for Medicare and Medicaid Services (CMS) to ensure that Medicaid provides a full continuum of SUD care. The purpose of this SPA is to ensure that recovery-oriented services in the community are reimbursed under the Medicaid State Plan.

Mainstream MCOs: **Inclusion of BH services for Adults in the Mainstream MCOs Currently Under the 1115 Demonstration**

Eligibility Requirements

All mainstream MCO Medicaid enrollees with a mental illness or SUD who meet the State's definition of medical necessity for one or more Medicaid State Plan covered BH services are eligible to receive the Medicaid covered benefits summarized in this section of the waiver (See the discussion on page 13 for a description of the benefits and delivery system for HARPs). The BH needs of other participants who utilize OPWDD services outside of waivers or the Developmental Disabilities Individual Care and Support Organization (DISCO) managed care plan will be served in the MCOs.

Mainstream MCOs must manage BH care for special populations including children participating in BH programs and HCBS waivers from both OMH and Office of Children and Family Services, also known as Transition Age Youth (TAY). Management of this population includes developing a transition plan to ensure continuity of care until age 23 or until the youth is stabilized in the adult system, whichever is later. MCOs must ensure that the child is screened for entry into a HARP and is transitioned to a HARP if that is the individual's choice.

MCOs will also provide the full range of medically necessary Medicaid services for members who have a first onset of psychosis. Individuals identified as having "First Episode Psychosis" (FEP) will be enrolled in HARPs and be eligible for 1915(i)-like services through the HARP.

Individuals living in a nursing facility or enrolled in a home and community-based waiver under managed long term care (LTC) are not enrolled in mainstream MCOs. Dual eligibles (persons who are both Medicaid and Medicare enrolled) will not be included in the demonstration at this time. New York will work with CMS on an additional demonstration amendment regarding any new populations at a later date. As new populations are moved into Medicaid Managed Care, the populations will become eligible for the full package of MCO benefits including these BH benefits.

Benefits and Cost-Sharing

All Medicaid State Plan BH services, including inpatient and outpatient hospital services with a primary BH diagnosis and community-based and clinic services for BH care, will be included under the MCO contract for enrolled beneficiaries in addition to the current array of PH services. Cost-sharing will not change from the current Medicaid FFS-approved State Plan. The MCO will ensure that the member is offered all eligible benefits. Medicaid covered services will be available statewide, using the State Medicaid definition of "medically necessary services". For all modalities of care, the duration of treatment will be determined by the member's needs and his or her response to treatment in the most integrated setting to support the participant's ability to live in the community. All services, for which a member is eligible, will, at a minimum, cover:

- The prevention, diagnosis, and treatment of health impairments.
- The ability to achieve age-appropriate growth and development.
- The ability to attain, maintain, or regain functional capacity.

Medicaid BH services will be provided by MCO credentialed providers including currently contracted Medicaid FFS BH service providers who meet established credentialing standards that include State licensure and program standards. The MCO will perform network development activities including providing technical assistance to new providers regarding enrollment in Medicaid. All MCOs must already contract with federally qualified health centers that may provide BH care through their scope of practice. Additionally, all MCOs will be required to contract with essential community BH providers including state operated behavioral health programs.

Each MCO's network must meet state and federal access to care requirements to ensure that the network is of sufficient size and scope, and includes the types and quality of providers necessary to deliver a comprehensive array of community-based BH services and to reduce reliance on more costly, restrictive levels of care, such as inpatient. If access problems are detected, the MCOs shall actively recruit, train, and/or subcontract with additional providers, including independent practitioners, to meet the needs of members. The State Plan is being revised to include a full array of Medicaid SUD community-based treatment services. The delivery of Medicaid BH/PH services will appear seamless to all members.

During the term of the contract, the MCOs may provide services that are cost-effective alternative treatment services and programs for enrolled members under 42 CFR 438.6(e). The contractor can implement cost-effective services and programs only after approval by the State.

The different Medicaid benefit packages are summarized in Table 2. Concurrent with this demonstration, the State is requesting a State Plan Amendment to move SUD clinic services to the Rehabilitation Option to provide services in a more recovery-oriented model and to add residential SUD services to ensure that Medicaid participants have a full array of SUD services available to them. We anticipate that more individuals will be covered under Medicaid through the State's Medicaid expansion in 2014. It is vital that the full array of BH services is included in the Medicaid Managed Care benefit package to ensure access and quality integrated care through the continuum of services. A few State Plan behavioral health services may remain fee-for-service in the first year of implementation and included in the MCO benefit package a year after implementation of the rest of the services in order to ensure continuity of care and financial stability for those services which need a longer implementation period.

The Department of Health (DOH) in collaboration with OMH and OASAS will prepare a readiness review tool and a readiness review of each MCO will be completed prior to implementation of the adult populations. The MCO must successfully complete all elements of the readiness reviews before it is approved to implement the BH specialty services for adults and, separately, before it accepts children's services transitioning from FFS.

Table 2. Benefits in Mainstream MCOs for all Medicaid Populations over the age of 20

Services	Current State Plan	SPA Change Submitted Separately from this 1115 Demonstration Amendment but for Inclusion in This Demonstration	Currently in NYS 1115 Benefit Package	Current delivery System (Either MCO or FFS)	Future MCO Benefit Package
Medically supervised outpatient withdrawal (OASAS services)	Yes	Rehabilitation option per 42 CFR 440.130	Yes	Managed care for MCO enrollees; FFS for non-MCO enrollees	Yes for MCO enrollees
Outpatient clinic and opioid treatment program (OTP) services (OASAS services)	Yes — clinic option per 42 CFR 440.90	Move to rehabilitation option per 42 CFR 440.130	Outpatient clinic and OTP is FFS for all Medicaid enrollees	FFS under clinic option	Yes for MCO enrollees
Outpatient clinic services (OMH services)	Yes — clinic option per 42 CFR 440.90		Temporary assistance to needy families (TANF) and safety net assistance (SNA) only;	Managed care for TANF and SNA; FFS for SSI and duals	Yes for MCO enrollees
Comprehensive psychiatric emergency program	Yes — outpatient hospital service (42 CFR 440.20)		TANF and SNA only; FFS for all SSI Medicaid recipients	Managed care for TANF and SNA; FFS for SSI and duals	Yes for MCO enrollees
Continuing day treatment	Yes — clinic option per 42 CFR 440.90		No	FFS only	Yes for MCO enrollees
Partial hospitalization	Yes — clinic option per 42 CFR 440.90		No	FFS only	Yes for MCO enrollees
PROS	Yes — rehabilitation option per 42 CFR 440.130		No	FFS only	Yes for MCO enrollees
ACT	Yes — rehabilitation option per 42 CFR 440.130		No	FFS only	Yes for MCO enrollees
Intensive case management/ supportive case management	Yes — TCM is being phased out; now using Health Home SPA authority		No	FFS only	Yes for MCO enrollees

Services	Current State Plan	SPA Change Submitted Separately from this 1115 Demonstration Amendment but for Inclusion in This Demonstration	Currently in NYS 1115 Benefit Package	Current delivery System (Either MCO or FFS)	Future MCO Benefit Package
Health home coordination	Yes — Health Home per 1945 of Social Security Act		No	Managed care for MCO enrollees; FFS for non-MCO enrollees	Yes for MCO enrollees
Inpatient hospital detoxification (OASAS service)	Yes — inpatient 42 CFR 440.10		Yes	Managed care for MCO enrollees; FFS for non-MCO enrollees	Yes for MCO enrollees
Inpatient medically supervised inpatient detoxification (OASAS Service)	Yes — inpatient 42 CFR 440.10		Yes	Managed care for for MCO enrollees; FFS for non-MCO enrollees	Yes for MCO enrollees
Inpatient treatment (OASAS service)	Yes — inpatient 42 CFR 440.10		TANF and SNA only; FFS for all SSI Medicaid recipients	Managed care for TANF and SNA; FFS for SMI, SSI and duals.	Yes for MCO enrollees
Rehabilitation services for residential SUD treatment supports (OASAS service)	No	Rehabilitation option per 42 CFR 440.130	No	FFS	Yes for MCO enrollees
Inpatient psychiatric services (OMH service)	Yes — inpatient 42 CFR 440.10		TANF and SNA only; FFS for all SSI Medicaid recipients	Managed care for TANF and SNA; FFS for SSI and duals	Yes for MCO enrollees
Rehabilitation services for residents of community residences	Yes — rehabilitation option per 42 CFR 440.130		No	FFS	Yes for MCO enrollees in year 2

Delivery System and Payment Rates for Services

There are several key features of the service delivery system under the BH component of the waiver:

- All members enrolled in mainstream MCOs will continue to have a choice of managed care entity.
- MCOs will contract with Health Homes.
- The current MCO contractors will continue to administer BH benefits already in their contracts and, through a request for qualification process, those MCOs found to be qualified to provide specialty BH services, will assume responsibility for administering BH benefits for the remaining specialty services currently under FFS for the currently covered MCO populations. MCOs not found qualified to assume management responsibility for BH care will need to contract with a managed BH organization (MBHO) and qualify with that MBHO to manage the BH care of enrollees.
- At any point after implementation, DOH in consultation with OMH and OASAS may introduce financial incentives and penalties. An incentive arrangement means any payment mechanism under which a contractor may receive additional funds over and above the capitated rates it was paid for meeting targets specified in the contract.
- All MCOs will continue to be paid an actuarially sound capitation rate per 42 CFR 438.6(c).
- Providers must be contracted with the MCOs to provide services within their approved scope of practice. Utilizing the freedom of choice waiver, the MCOs will contract with providers. Beneficiaries may choose the provider they prefer from a list of contracted providers.
- The State's current quality improvement strategy and 1115 demonstration evaluation design will be amended to include monitoring of the entire BH benefit package under the MCOs.
- A contract amendment for MCOs will be submitted to CMS for approval no later than 30 days after demonstration amendment approval.
- A readiness review tool will be developed and a readiness review of each MCO will be completed no later than 60 days prior to implementation.
- MCOs may utilize telemedicine for State Plan services to the extent that it is permissible in the FFS program, including compliance with all federal requirements.

If the MCO network is unable to provide necessary medical services covered under the contract to a particular enrollee, the MCO will be required to adequately and timely cover these services and supports out of network for the enrollee, for as long as the MCO is unable to provide them. This will include up to a 2 year period following the transition of the BH benefits to managed care during which time the MCO will reimburse non-participating BH practitioners to ensure that continuity of care occurs. This transition may be extended based on mutual agreement of the MCO and non-participating programs and practitioners. After 90 days, the MCO may apply utilization review criteria to individuals under the care of non-participating providers.

MCOs will be required to offer contracts to BH agency providers licensed or certified by OMH or OASAS who currently serve a threshold number of Medicaid Managed Care enrolled Medicaid beneficiaries. This network requirement will be in place for the first two years of operation. NYS anticipates that MCOs will be required to pay FFS rates to current outpatient behavioral health

providers for the first 24 months of operation unless a mutually agreed suitable alternative has been approved by the state.

MCO's Roles and Responsibilities

The qualified MCO will arrange, manage and be at risk for any Medicaid covered service that is currently delivered as well as any BH State Plan service being moved into managed care through this waiver. To the extent that an MCO is not able to meet the requirements for the management of the specialty BH services, the MCO will be required to contract with a managed BH organization (MBHO) to manage the BH care of enrollees. This partnership will be subject to the State's process for Plan qualifications

Each MCO will be required to collaborate with OMH and OASAS to: (1) implement a standardized protocol to identify common BH risks in primary care settings and (2) provide necessary education and brief intervention when clinically appropriate in order to facilitate referrals of participants who screen positive to an appropriately credentialed and qualified BH provider. This includes, but is not limited to, selecting appropriate screening tools and establishing provider requirements to follow the established screening and referral protocols, including the Screening, Brief Intervention and Referral to Treatment protocol.

The MCO will collaborate with OMH and OASAS to establish a list of approved screening tools meeting State requirements. Screening will occur at the point of service delivery using age appropriate periodicity.

Health and Recovery Plans (HARPs): **Eligibility, Enrollment, and Benefits**

In order to better treat participants with SMI and/or SUD, members who meet targeting criteria and identified risk factors will be enrolled in HARPs.[6] For members meeting the targeting criteria and risk factors who also meet need-based criteria, HARPs will provide members with access to an enhanced benefit package of 1915(i)-like Home and Community-Based Services (HCBS). HARP members can receive these services based an assessment of their functional needs. These enhanced benefits, such as behavioral supports in residential, day, and home settings, are designed to enable recipients to live in the most integrated setting possible. HARPs, operating within the MCOs as separate lines of business, will contract with the Health Homes and ensure that all Health Home and HCBS requirements and assurances are met.

Eligibility Requirements for HARP and 1915(i)-like

Medicaid beneficiaries who are eligible for mainstream MCOs are eligible for enrollment in the HARP if they meet either:

- Target criteria and risk factors as defined below (Individuals meeting these criteria will be identified through quarterly Medicaid data reviews by Plans and/or NY State); or
- Service system or service provider identification of individuals presenting with serious functional deficits as determined by:
    - A case review of individual's usage history to determine if Target Criteria and risk factors are met or

[6] HARP enrollment will be open to Medicaid beneficiaries with serious mental illness and/or substance use disorders, who have risk factors demonstrated by a historical pattern of high utilization/high cost.

- Completion of HARP eligibility screen

*Target Criteria***:** The State of New York has chosen to define HARP targeting criteria as:

- Medicaid enrolled individuals over 20 years of age;
- SMI diagnoses as specified by OMH;
- SUD diagnoses or diagnoses combinations as specified by OASAS;
- Eligible to be enrolled in Mainstream MCOs;
- Not Medicaid/Medicare enrolled ("duals");
- Not participating or enrolled in a program with the Office for People with Developmental Disabilities (OPWDD) (i.e., participating in an OPWDD program).

Risk Factors: For individuals meeting the targeting criteria, HARP enrollment will occur when any of the following risk factors exist:

- Meets the HARP eligibility screen criteria that at least includes the needs-based criteria for 1915(i)-like eligibility
- Supplemental Security Income (SSI) individuals who received an "organized" MH service, in the year prior to enrollment.
- Non-SSI individuals with three or more months of Assertive Community Treatment (ACT) or Targeted Case Management (TCM), Personalized Recovery Oriented Services (PROS) or prepaid mental health plan (PMHP) services in the year prior to enrollment.
- SSI and non-SSI individuals with more than 30 days of psychiatric inpatient services in the three years prior to enrollment.
- SSI and non-SSI individuals with 3 or more psychiatric inpatient admissions in the three years prior to enrollment.
- SSI and non-SSI individuals discharged from OMH Psychiatric Center after an inpatient stay greater than 60 days in the year prior to enrollment.
- SSI and non-SSI individuals with a current or expired Assisted Outpatient Treatment (AOT) order in the five years prior to enrollment.
- SSI and non-SSI individuals discharged from correctional facilities with a history of inpatient or outpatient behavioral health treatment in the four years prior to enrollment.
- Residents in OMH funded housing for persons with serious mental illness in any of the three years prior to enrollment.
- Members with two or more services in an inpatient/outpatient chemical dependence detoxification program within the year prior to enrollment.
- Members with one inpatient stay with a SUD primary diagnosis within the year prior to enrollment.
- Members with two or more inpatient hospital admissions with SUD primary diagnosis or members with an inpatient hospital admission for an SUD related medical diagnosis-related group and a secondary diagnosis of SUD within the year prior to enrollment.

- Members with two or more emergency department (ED) visits with primary substance use diagnosis or primary medical non-substance use that is related to a secondary substance use diagnosis within the year prior to enrollment.
- Individuals transitioning with a history of involvement in children's services (e.g., RTF, HCBS, B2H waiver, RSSY)

Needs-based Criteria: All individuals in the HARP will be evaluated for eligibility for 1915(i)-like services. Individuals for whom it is believed that they will be eligible for the 1915(i)-like services will receive a conflict-free evaluation/assessment from an appropriately qualified individual, using a standardized clinical and functional assessment tool consistent with the State's approved Balancing Incentive Payment Program. Individuals meeting one of the needs-based criteria identified below, which are less stringent than HCBS institutional levels of care, will be eligible for 1915(i)-like services:

- An individual with at least "moderate" levels of need as indicated by a State designated score on a tool derived from the interRAI Assessment Suite.
- An individual with need for HCBS services as indicated by a face to face assessment with the interRAI Assessment Suite and a risk factor of a newly-emerged psychotic disorder suggestive of Schizophrenia herein called individuals with First Episode Psychosis (FEP). Individuals with FEP may have minimal service history.
- A HARP enrolled individual who either previously met the needs-based criteria above or has one of the needs based historical risk factors identified on page 14; AND who is assessed and found that, but for the provision of HCBS for stabilization and maintenance purposes, would decline to prior levels of need (i.e., subsequent medically necessary services and coordination of care for stabilization and maintenance is needed to prevent decline to previous needs-based functioning).

Enrollment Process

New York will phase-in enrollment to HARPs (i.e., New York City versus the rest of the state). It is estimated that statewide there are initially 140,000 Medicaid Managed Care enrollees – 80,000 in New York City and 60,000 in the rest of the state - meeting targeting criteria and risk factors that will be enrolled in the HARPs.

Once these initial enrollees are identified and enrolled, each will receive an evaluation for 1915(i)-like service eligibility. Those determined eligible for 1915(i)-like services will receive a comprehensive assessment. Targeted participants in the rest of the state meeting the targeting and risk factors will follow a similar enrollment, evaluation, and assessment process during the second implementation phase.

It is estimated that there are approximately 38,000 individuals in year 1 who will meet the 1915(i)-like targeting, risk factors and needs-based criteria. NYS expects this number to grow to approximately 50% of HARP enrollees over the first five years.

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)(1)(D)(ii) should membership in the 1915(i)-like authority exceed or lag the projections above.

A key goal in this managed care design is to avoid disrupting access the physical health care for individuals already enrolled in a mainstream Plan. Therefore, individuals initially identified as HARP eligible who are already enrolled in an MCO with a HARP will be passively enrolled in that

Plan's HARP. This will ensure that Plan members will continue to have access to the same network of physical health services as the new BH benefits are brought into the Plan. Once a member is identified as HARP eligible, they can enroll in a HARP at any point. Members will be given 90 days to opt out before they are locked into the HARP. After that opt-out period, they are locked into that Plan until the next open enrollment period. As part of the passive enrollment process, these individuals will be informed about HARP benefits as well as their ability to stay in their existing mainstream Plan or chose another HARP.

Individuals initially identified as HARP eligible who are already enrolled in an MCO without a HARP will be notified of their HARP eligibility and referred to an enrollment broker to help them decide which Plan is right for them. If the individual chooses to change MCOs, then the enrollment and assessment process above will be followed.

Benefits[7]

Participants receiving services through the HARPs will be eligible to receive all Medicaid State Plan services available in the mainstream MCOs as noted above. Additionally, participants will be eligible to receive 1915(i)-like services when indicated by a functional assessment and specified in their plan of care. Definitions of these services may be found in Appendix A.

All individuals enrolled in the HARP will be enrolled in a Health Home, and will be assigned a Health Home care manager (or other qualified individual) who will initiate a person-centered planning process to determine a plan of care. This will include the completion of an evaluation for 1915(i)-like needs based eligibility. This process will comply with federal conflict-free case management requirements.

The health home care management services include comprehensive care management; care coordination and health promotion; comprehensive transitional care from inpatient to other settings, including appropriate follow-up; individual and family support, which includes authorized representatives; referral to community and social support services if indicated; and the use of HIT to link services, as feasible and appropriate. In addition care management provides service planning and coordination to identify needed 1915(i)-like and other HCBS services; brokering to obtain and integrate these services and supports; advocacy to resolve issues that impede access to needed services; monitoring and reassessment of services based on changes in member's

[7] From the preamble of the proposed 1915(i) regulation published in the Federal Register on 5/3/2012:

The needs-based criteria for coverage of individual services provided within a State's section 1915(i) benefit are subject to the same requirements as the needs based eligibility criteria for the benefit, and may not limit or target any service based on age, nature or type of disability, disease, condition, or residential setting, but could include risk factors or take into account service history. However, section 1915(i)(7) of the Act provides States with the option to target eligibility for the benefit to specific populations.

Proposed regulation 42 CFR §441.659 Needs-based criteria and evaluation: (a) Needs-based criteria. The State must establish needs-based criteria for determining an individual's eligibility under the State plan for the HCBS benefit, and may establish needs based criteria for each specific service. Needs-based criteria are factors used to determine an individual's requirements for support, and may include risk factors. The criteria are not characteristics that describe the individual or the individual's condition. A diagnosis is not a sufficient factor on which to base a determination of need. A criterion can be considered needs-based if it is a factor that can only be ascertained for a given person through an individualized evaluation of need.

condition and annual reassessment requirements; and assessment to determine the need for services to members.

Health Home care management will also include efforts to identify individuals with co-morbidities including mental illness, SUD, and criminal justice involvement.[8] For these individuals, care managers will work to coordinate services across the multiple systems. Screening, monitoring, and outreach efforts will be used to ensure engagement in services and successful diversion and/or transition from criminal justice to community-based services.

The results and goals identified through the functional assessment will be addressed through the personal centered planning process and incorporated into the individual's person-centered plan of care. HARP enrollees will be reevaluated for 1915(i)-like eligibility and services on an annual basis or as needed.

Table 3: HCBS Services for Adults Meeting Targeting and Functional Needs

Services	Currently in the Medicaid State Plan for BH	Proposed Under this 1115 Demonstration Amendment as a 1915(i)-Like Service	Future HARP Benefit Package for Adults Meeting Targeting and Functional Criteria
Rehabilitation • Psychosocial Rehabilitation • Community Psychiatric Support and Treatment (CPST) • Crisis Intervention	No	Yes	Yes
Peer Supports	No	Yes	Yes
Habilitation • Residential Supports/ Supported Housing	No	Yes	Yes
Respite • Short-term Crisis Respite • Intensive Crisis Respite	No	Yes	Yes
Non-medical transportation	No	Yes	Yes
Family Support and Training	No	Yes	Yes
Employment Supports • Pre-vocational • Transitional Employment • Intensive Supported Employment • On-going Supported Employment	No	Yes	Yes
Education Support Services	No	Yes	Yes

[8] Medicaid will only enroll and reimburse individuals with criminal justice involvement when allowed under Medicaid authority (i.e., individuals with mental health and SUD needs on parole, individuals with mental health and SUD needs transitioning to the community, and individuals with mental health and SUD needs admitted to a medical facility outside of penal control)

Services	Currently in the Medicaid State Plan for BH	Proposed Under this 1115 Demonstration Amendment as a 1915(i)-Like Service	Future HARP Benefit Package for Adults Meeting Targeting and Functional Criteria
Supports for self-directed care [phased in as a pilot; see details below] • Information and Assistance in Support of Participation Direction • Financial Management Services	No	Yes	Yes

During the initial three years of implementation of this benefit package, subject to CMS approval, New York will work to design and pilot test an initial individual prospective budget system to ensure equitable resource allocation among individual enrolled in HARPs and eligible for the 1915(i)-like enhanced services . The process will generally include a cost matrix to assigning a "base" cost for each individual's budget. The base will be reflective of the cost to fund services for persons currently enrolled in the waiver who are of similar age, life circumstances, and acuity based on the interRAI assessment scale. The acuity based factors will be tested during the initial years of the enhanced service package and phased in accordingly. Life circumstances are reflective of age ranges and current life stages such as: home, school-home, school-residential, employment-home, employment–residential. The cost matrix will be updated periodically to ensure that it accurately reflects the average cost of services to participants in each life stage at each acuity. As more experience is gained with the resource allocation methodology, the individual service limits outlined in the service definitions may be revisited, subject to CMS approval. The resource allocation methodology will enable the State to ensure that HCBS resources are distributed in an objective manner way across all HCBS members, using a standardized tool for needs assessment that allows maximum participant direction and choice.

Cost-Sharing

New York will not utilize institutional financial eligibility standards under this portion of the demonstration (i.e., no .217-like group). Therefore patient liability is not applicable and, consistent with Medicaid regulations and statutes will not be collected for participants eligible for Medicaid under the community financial standards. At this time, the Medicaid spend-down group is not enrolled in mainstream MCOs. There is no nominal Medicaid cost-sharing approved in the State Plan for mental health or SUD services.

Delivery System and Payment Rates for Services

MCOs with proven experience in managed care with a Medicaid BH population particularly with persons with SMI and SUD will have the opportunity to have two lines of business, a basic managed care plan including all State Plan BH services and/ or a HARP which includes all State Plan BH services and HCBS/1915(i)-like services. Individuals eligible for HARP will have the choice of HARP or mainstream MCO. In a rural area per 42 CFR 412.62(f)(1)(ii), there may only be one HARP available. In that case, the HARP must comply with all requirements under the rural exception per 42 CFR 438.52(b).[9]

[9] If the rural exception is utilized, beneficiaries must be able to choose from at least two physicians or case managers; and to obtain services from any other provider under any of the following circumstances: 1) the service or type of

HARPs will be paid an actuarially sound capitated rate per 42 CFR 438.6(c). Utilizing the freedom of choice waiver granted under this demonstration, HARPs will contract with the full range of required providers including those meeting the HCBS requirements. Beneficiaries may choose the provider they prefer from a list of contracted providers. If the HARP's network is unable to provide necessary medical services or HCBS supports covered under the contract to a particular enrollee, the HARP will be required to adequately and timely cover these services and supports out of network for the enrollee, for as long as the HARP is unable to provide them. This will include up to a 2 year period following the transition of the BH benefits to managed care during which time the MCO will reimburse non-participating BH practitioners to ensure that continuity of care occurs. This transition may be extended based on mutual agreement of the MCO and non-participating programs and practitioners. After 90 days, the MCO may apply utilization review criteria to individuals under the care of non-participating providers.

HARPS will be required to offer contracts to BH agency providers licensed or certified by OMH or OASAS who currently serve a threshold number of Medicaid managed care enrolled Medicaid beneficiaries. NYS anticipates that HARPs will be required to pay FFS rates to current behavioral health providers for the first 24 months of operation.

Reporting, Program Monitoring, and Quality Management

Progress updates: During the first year of implementation of the waiver, the State will submit regular progress updates to CMS regarding the implementation of the BH services from FFS to managed care under the MCOs.

Reporting: In addition to the requirements in Section 18.5.x of the MCO Model Contract, The Plan shall prepare and submit the standard reports to the State as specified in a revised Quality Strategy that will incorporate the BH modification that are the subject of this 1115 waiver. HARP reporting will comply with federal HCBS requirements.

Additionally, Plans will conduct periodic satisfaction surveys of BH recipients using State approved survey tools and protocols. Plans will separately track, trend, and report BH complaints, grievances, and appeals.

QM: The qualified MCOs will incorporate BH-specific performance measures and performance improvement projects into its QM program which will be consistent with the State's quality strategy and federal requirements for quality monitoring. The QM program, including performance metrics, performance improvement projects, and clinical outcome measures, is subject to the review and approval of DOH in collaboration with OMH and OASAS. Each qualified MCO's BH QM requirements include:

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provider (in terms of training, experience, and specialization) is not available within the HARP network; 2) the provider is not part of the HARP network, but is the main source of a service to the beneficiary, provided that a) the provider is given the opportunity to become a participating provider under the same requirements for participation in the HARP network as other network providers of that type and b) if the provider chooses not to join the network, or does not meet the necessary qualification requirements to join, the enrollee will be transitioned to a participating provider within 60 days (after being given an opportunity to select a provider who participates); 3) the only plan or provider available to the recipient does not because of moral or religious objections provide the service the enrollee seeks; 4) the recipient's primary care provider or other provider determines that the recipient needs related services that would subject the recipient to unnecessary risk if received separately and not all of the related services are available within the network; 5) the state determines that other circumstances warrant out-of-network treatment.

- Modifying and submitting the MCO's Quality Assurance Program Initiative (QAPI) to NYS for review and approval of BH elements.
- Modifying and submitting the MCO's Utilization Monitoring (UM) plan for BH elements, including prior authorization requirements, procedures, and timeframes and any other UM strategy proposed to DOH, OMH and OASAS for review and approval.
- Closely monitoring and reporting BH-specific Healthcare Effectiveness Data and Information Set (HEDIS) metrics and other performance measures against targeted benchmarks where available.
- The MCOs will be required to submit Quality Assurance and Performance Improvement (QAPI) and UM plans for BH to DOH, as appropriate, for review and approval prior to implementation. DOH, in collaboration with OMH and OASAS will make a preliminary selection of BH HEDIS and other performance measures, including CMS core measures, with the understanding that the underlying methodology may require adjustment and measures may be updated on an annual basis to reflect progress in achieving program goals. The preliminary list of measures includes at a minimum:
    - Post inpatient discharge ambulatory follow up.
    - Initiation and engagement of alcohol and other drug dependence treatment
    - Adherence to antipsychotics for participants with schizophrenia.
    - Antidepressant medication management for participants with a diagnosis of major depressive disorder.

Program monitoring: In addition to the readiness reviews noted above, DOH in collaboration with OMH and OASAS will also modify procedures for conducting monitoring on a quarterly and annual basis to include BH monitoring. This will include quarterly and annual monitoring meetings with the MCO, OMH, and OASAS to review quarterly and annual reports and completion of a compliance review no less than every three years.

DOH in consultation with OMH and OASAS will update the State's quality improvement strategy for MCOs to include state monitoring responsibilities and oversight for BH. OMH and OASAS, along with the Local Governmental Units (LGUs), will assist DOH in programmatic oversight for MH/SUD performance. The State's External Quality Review Organization will include BH monitoring in its annual review.

Implementation of the Demonstration

BH services currently managed under FFS will be managed under the MCO contracts, through a contract amendment, with the following phase-in schedules.

- New York will issue a request for qualifications (RFQ) by February, 2014 to determine the competence of MCOs/HARPs to manage specialty BH benefits for adults in New York City, with an implementation date of January, 2015. If an MCO or HARP is found not qualified to manage specialty BH benefits for adults, the MCO will need to subcontract with a managed BH Organization and resubmit their Request for Qualification.
- New York will also issue a RFQ by February, 2014 to determine the competence of MCOs and HARPs to manage specialty BH benefits for adults in the remainder of New York State, with an implementation date of July, 2015. If an MCO is found not qualified to manage specialty BH benefits for adults, the MCO will need to subcontract with a managed BH Organization and resubmit their Request for Qualification.

- New York will phase in a pilot for self-direction of 1915(i)-like HCBS services over a 3 year period in this waiver. Supports for self-direction are included in the benefit package under this 1115 amendment and operationalization of those supports will be tested in a pilot.

As part of each RFQ process, behavioral health rates will be provided to MCOs. In addition, the state will provide a databook that includes summary level data on penetration, utilization, average unit cost, and total cost by category of service (COS). The data will be specific to the populations, services, and costs in the mainstream MCOs/HARPs. The databook will cover the two most recent twelve-month periods for which data is available at the time.

New York will conduct a readiness review of the MCOs/HARPs prior to each phase-in implementation date. The timing of the reviews will allow a minimum of two-months for resolution of issues identified during the review. The reviews will include desk and onsite review components and address readiness in the following areas:

- Provider capacity in BH services.
- Member transitions from FFS to the MCO/HARP provider network ensuring continuity of care.
- The documented Management Information Systems (MIS) functionality and processes; the OMH, OASAS and DOH provider file data load and maintenance; the automated authorization management system, including the conversion of current authorization data and maintenance; encounter data file transfers; data exchange with the MCO/HARP; and claims administration.
- Member service functionalities including the telephone call line, website, and enrollee/recipient communications.
- The policies, procedures, and processes governing member services including BH-specific protocols for management of care including appointment access, network adequacy, credentialing and provider relations; UM including medical necessity criteria, clinical guidelines, prior authorization, concurrent review, outlier management, care management and care coordination; medical management including notice of action, denials, grievances, and administrative hearings; and QM.
- An outline of the components of a care plan, how the data is stored, and what data will be transmitted to relevant providers.
- Staffing resources, requirements (education, training, experience) and performance monitoring, by department.
- Reporting capabilities, including utilization, cost, financial, quality and administrative indicators, and performance metrics.

Demonstration Financing and Budget Neutrality

Budget neutrality demonstration will be forthcoming.

List of Proposed Waivers and Expenditure Authorities

1. Statewideness Section 1902(a)(1)

To enable the State to conduct a phased transition of HCBS for Medicaid beneficiaries from FFS to a managed care delivery system based on geographic service areas.

2. Amount, Duration, and Scope Section 1902(a)(10)(B)

To the extent necessary to enable the State to vary the amount, duration, and scope of services offered to participants, regardless of eligibility category, by providing additional HCBS services to enrollees in certain targeted programs.

3. Freedom of Choice Section 1902(a)(23)(A)

To the extent necessary, to enable the State to restrict freedom of choice of provider through the use of mandatory enrollment in managed care plans for the receipt of covered services. No waiver of freedom of choice is authorized for family planning providers or emergency providers.

4. Direct Payment to Providers Section 1902(a)(32)

To the extent necessary to permit the State to have participants self-direct expenditures for HCBS LTC and supports. This will be phased in through a pilot project over the first 3 years of operation of the amendment.

Public Process and Notice

The MRT BH Work Group began meeting on June 30, 2011 in New York City and held several additional meetings. Meeting dates and materials can be found at:
http://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health_reform.htm

The Department, OASAS and OMH continue to provide presentations and meet with Managed Care Plans, Provider Associations, parents and constituents regarding this important BH Transition from FFS to Medicaid Managed Care.

The proposed amendment was placed on public notice on November 27, 2013 for 30 days. This amendment incorporates changes and suggestions by the public from that process.

Demonstration Administration

Please provide the contact information for the State's point of contact for the demonstration application.

Name and Title: Linda Kelly, Project Director NYS DOH Behavioral Health Transition
Telephone Number: 518-486-5141
Email Address: lmk04@health.state.ny.us

Attachment C: HCBS Service Definitions for HARPs

Rehabilitation

Psychosocial Rehabilitation (PSR) and Community Psychiatric Support and Treatment (CPST) services are provided as part of a comprehensive specialized psychiatric program available to all Medicaid eligible adults with significant functional impairments meeting the need levels in the 1915(i)-like authority resulting from an identified mental health or substance use disorder diagnosis. The medical necessity for these rehabilitative services must be determined by a qualified behavioral health practitioner or physician who is acting within the scope of his/her professional license and applicable state law and furnished by or under the direction of a licensed or credentialed practitioner, to promote the maximum reduction of symptoms and/or restoration of an individual to his/her best age-appropriate functional level conducting an assessment consistent with state law, regulation, and policy. Rehabilitation services can be provided to motivate an individual to select goals that he or she would like to accomplish but are unable to due to their behavioral health condition. Individuals may be engaged to identify personal life role goals for employment, education and/or housing and supported to engage in comprehensive services in order to attain such goals. Services will be reviewed during the planning process to insure that no duplication exists. A unit of service is defined according to the Healthcare Common Procedure Coding System (HCPCS) approved code set unless otherwise specified.

Psychosocial Rehabilitation:

Definitions:

PSR services are designed to assist the individual with compensating for or eliminating functional deficits and interpersonal and/or environmental barriers associated with their Mental Health and/or Substance Use condition. Activities included must be intended to achieve the identified goals or objectives as set forth in the individual's Individual Recovery Plan. The intent of PSR is to restore the individual's functional level to the fullest possible 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. PSR is a face-to-face intervention with the individual who has a MH/SUD diagnosis present. Services may be provided individually or in a group setting and should utilize (with documentation) evidence-based rehabilitation interventions. This service may include the following components:

- Rehabilitation, counseling, and support to restore social and interpersonal skills necessary to increase community tenure, enhance interpersonal skills, establish support networks, increase community awareness, develop coping strategies, and effective functioning in the individual's social environment including home, work, and school.
- Rehabilitation, counseling, and support to develop skills and symptom stabilization necessary to improve self-management of the negative effects of psychiatric, emotional symptoms, or recurrent relapse to substance use 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.
- Rehabilitation, counseling, and support necessary for the individual to implement learned skills so the person can remain in a natural community location.
- Rehabilitation, counseling, and support necessary for the individual to participate in volunteer activities for pre-vocational or civic duty purposes.

- Assisting the individual with effectively responding to or avoiding identified precursors or triggers that result in functional impairments.
- Ongoing in-vivo assessment of the individual's functional skill and impairment levels that is used to select PSR interventions and periodically assess their effectiveness in achieving goals. Workers who provide PSR services should periodically report to a supervising licensed practitioner on participants' progress toward the recovery and re-acquisition of skills.

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 and Community Psychiatric Support and Treatment are limited to no more than a total of 500 hours in a calendar year.

Community Psychiatric Support and Treatment (CPST):

The CPST services are defined as follows:

CPST are goal-directed supports and solution-focused interventions intended to achieve identified goals or objectives as set forth in the individual's Individual Recovery Plan. CPST is a face-to-face intervention with the individual, family or other collateral supports. The service may include the following components to meet the needs of the individuals with mental health or mental health co-occurring diagnosis:

- Assist the individual and family members or other collateral supports to identify strategies or treatment options associated with the individual's mental illness, 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 treatment and 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 collateral supports 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 collateral supports with identifying a potential psychiatric or personal crisis, developing a crisis management plan and strategies to take medication regularly, seeking other supports to restore stability and functioning.
- Provide restoration, rehabilitation, assistance with employment, housing and education goals, and support to connect with additional services for attaining and sustaining the identified goals.

- Assist the individual with daily living skills 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 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 manifestation.

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

Crisis Intervention

Mobile Crisis Intervention:

Mobile Crisis Intervention (CI) services are provided as part of a comprehensive specialized psychiatric services program available to all Medicaid eligible adults with significant functional impairments meeting the need levels in the 1915(i)-like authority resulting from an identified mental health or co-occurring diagnosis.

Definitions:

- CI services are provided to a person who is experiencing a psychiatric crisis, are designed to interrupt and/or ameliorate a crisis experience including a preliminary assessment, immediate crisis resolution and de-escalation. The goals of CIs are engagement, symptom reduction, stabilization, and restoring individuals to previous level of functioning. All activities must occur within the context of a potential or actual psychiatric crisis. CI is a face-to-face intervention and can occur in a variety of locations, including an emergency room or clinic setting, or other community locations where the person lives, works, attends school, and/or socializes. Coordination between emergency room staff and crisis service providers will divert from inpatient admissions when appropriate. CI services include the following components:
    - Referral and linkage to appropriate community services to avoid more restrictive levels of treatment.
    - A preliminary assessment of risk, mental status, and medical stability; and the need for further evaluation or other mental health services. Includes contact with the client, family members, or other collateral sources (e.g. caregiver, school personnel) with pertinent information for the purpose of a preliminary assessment, treatment and/or referral to other alternative mental health services at an appropriate level.
    - Short-term CIs include crisis resolution and de-briefing with the identified Medicaid eligible individual and the treatment provider.
    - Follow-up with the individual, and when appropriate, with the individuals' caretaker and/or family members.
    - Consultation with a physician or other qualified providers to assist with the individual's specific crisis.

Empowerment Services - Peer Supports

Peer Support (PS) services are peer-delivered services with a rehabilitation and recovery focus designed to promote skills for coping with and managing mental health and/or SUD symptoms

while facilitating the utilization of natural resources and the enhancement of recovery-oriented principles such as hope and self-efficacy, and community living skills. Activities included must be intended to achieve the identified goals or objectives as set forth in the consumer's individualized care plan, which delineates specific goals that are flexibly tailored to the consumer and attempt to utilize community and natural supports.

Peer supports services are also intended for outreach and engagement activities and to help people with supports as they move from one level of care to another.

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. Persons providing these services will do so through the paradigm of the shared personal experience of recovery.

Certified Peer Specialists are appropriately supervised treatment team members who will play an integral role in care planning including the Wellness Recovery Action Plan (WRAP), treatment planning and the development of psychiatric advance directives (PAD). Training and certification 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.

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 also receive this duplicative service.

Habilitation

Residential Supports in Community Settings

Residential Supports services are designed to assist residents with acquiring, retaining and improving the necessary skills needed to live successfully in home and community-based settings. This service may be delivered in the participant's home or in local, public community environments as described in the service plan, such as libraries or stores.

Residential Supports services are necessary, as specified by the service plan, to enable the participant to integrate fully into the community and ensure the health, welfare, safety and maximum independence of the participant. Residential Supports providers will coordinate and ensure access to necessary medical and clinical services. Residential Supports may be provided when the provider of Residential Supports services is also the provider of the housing for the participant.

Residential supports are designed to assist participants with a mental health and/or substance use disorder or co-occurring diagnosis 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.

Residential Supports are skill based and individualized and will be provided to meet the participant's needs as determined by the assessment performed in accordance with Department requirements and as outlined in the participant's service plan. Supports include management of symptoms of Mental Health and/or Substance Use Disorder that impact stable living in a community setting.

Residential Supports services may help participants develop skills necessary for community living, such as:

- Instrumental Activities of Daily Living (IADLs) including: 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.

- Instruction in developing or maintaining financial stability and security (e.g., understanding budgets, managing money and the right to manage their own money).

Residential Supports provide onsite and offsite modeling, training, and/or supervision to assist the participant in developing maximum independent functioning in community living activities. This service also includes assistance with medication administration and the performance of health-related tasks to the extent State law permits.

The cost of transportation provided by Residential Supports service providers to and from activities is included as a component within the rate of the Residential Supports services and, therefore, is reflected in the rate for the service.

Services must be delivered in a manner that supports the participant's communication needs including, but not limited to, age appropriate communication, translation services for participants that are of limited-English proficiency or who have other communication needs requiring translation, assistance with the provider's understanding and use of communication devices used by the participant.

The total hours for Residential Supports/Supported Housing are limited to no more than a total of 250 hours in a calendar year. Time limited exceptions to this limit for individuals transitioning from institutions[10] 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.

Respite

Short-term Crisis Respite:

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 imminent risk for an escalation of symptoms that cannot be managed in the person's home environment without onsite supports and/or a loss of adult role functioning. It is for individuals who do not pose a risk to the safety of themselves or others. Crisis respite is provided in site-based residential settings or with staff at the individual's home. It may be used when acutely challenging emotional crisis occur which the individual is unable to manage without intensive assistance and support.

Crisis Respite services may be delivered by peers or para-professionals. Referrals to Crisis Respite may come from the emergency room, mobile crisis teams, the community, self-referrals, or as part of a step-down plan from an inpatient setting. Services offered may include: site-based crisis residence, peer support, either on site or as a wrap-around service during the respite stay, health and wellness coaching, wrap planning, wellness activities, family support, conflict resolution, and other services as needed. Crisis Respite is not intended as a substitute for permanent housing arrangements.

Ongoing communication between individuals receiving crisis respite, crisis respite staff, and the individuals' established mental health providers is recommended to assure collaboration

[10] Institutions include nursing homes, adult homes, state operated psychiatric centers, and residences on the grounds of psychiatric centers.

and continuity in managing the crisis situation and identifying subsequent support and service systems. 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 recipients' plan of care. Participants are encouraged to receive crisis respite in the most integrated and cost-effective settings appropriate to meet their respite needs.

Use of Crisis Respite should be no longer than 1 week per episode, and use of crisis respite by an individual is not to exceed a maximum of 45 days per year. Individual stays of greater than 72 hours require prior authorization. Individuals requiring 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.

Intensive Crisis Respite:

Intensive Crisis Respite (ICR) is a short-term, residential care and clinical intervention strategy for individuals who may need inpatient care; or have a mental health or co-occurring diagnoses and are experiencing acute escalation of mental health symptoms. Individuals in need of ICR are at imminent risk for loss of functional abilities, and raise safety concerns for themselves and others. The immediate goal of ICR is to provide supports to help the individual stabilize and return to previous level of functioning. This service can be provided as a step-down from inpatient hospitalization, ER diversion, or referral from mobile crisis teams or another clinician. Intensive crisis respite may be provided in clinically staffed, community-based sites. ICR services are delivered by a combination of licensed medical and mental health professionals and para-professionals. Services offered may include: comprehensive psychiatric, health, and wellness assessments, individual and group counseling, training in de-escalation strategies, medication management, peer support, WRAP planning, wellness activities, family support, conflict resolution, and other services as needed. 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 recipients' plan of care. Participants are encouraged to receive respite in the most integrated and cost-effective settings appropriate to meet their respite needs. Use of Intensive Crisis Respite should not exceed a maximum of 45 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.

Use of Intensive Crisis Respite should be no longer than 1 week per episode and use of crisis respite by an individual is not to exceed a maximum of 45 days per year. Individual stays of greater than 72 hours require prior authorization. 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.

Support Services

Family Support and Training

This service provides the training and support necessary to support and to ensure engagement and active participation of the family in the treatment planning process and with the ongoing implementation and reinforcement of skills learned throughout the treatment process. For purposes of this service, "family" is defined as the persons who live with or provide care to a

person receiving services, 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 consumer. Training includes instruction about treatment regimens and use of equipment specified in the plan of care, and shall include updates, as necessary, to safely maintain the individual at home. All family support and training must be included in the individual’s written plan of care and for the benefit of the Medicaid covered individual with a diagnosis of mental health or substance use disorder. Allowable activities include:

- Training on treatment regimens 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);
- Development and enhancement of the families specific problem-solving skills, coping mechanisms, and strategies for the individuals symptom/behavior management including substance use or relapse to substance use;
- Collaboration with the family and caregivers in order to develop positive interventions to address specific presenting issues and to develop and maintain healthy, stable relationships among all caregivers, including family members, in order to support the participant. 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 mental illness or substance use disorder and treatment;
- Assisting the family in understanding various requirements of the waiver process, such as the 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 mental illness/addictive disorder concerns while living in the community (e.g., training on system navigation and Medicaid interaction with other individual-serving systems);
- Training on community integration;
- Training on behavioral intervention strategies;
- Training on mental health conditions, services and supports;
- Training and technical assistance on caring for medically fragile individuals.

The total combined hours for Family Support and Training are limited to no more than a total of 30 hours in a calendar year.

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 necessary, as specified by the service plan, to enable participants to gain access to authorized home and community based services that enable them to integrate more fully into the community and ensure the health, welfare, and safety of the participant.

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 service plan.

Transportation services consist of:

- Transportation (Mile)

  This Transportation service is delivered by providers, family members, and other qualified, licensed drivers. Transportation (Mile) is used to reimburse the owner of the vehicle or other qualified, licensed driver who transports the participant to and from services and resources related to outcomes specified in the participant's service plan. The unit of service is one mile. Mileage can be paid round trip. A round trip is defined as from the point of first pickup to the service destination and the return distance to the point of origin.

  When Transportation (Mile) is provided to more than one participant at a time, the provider will divide the shared miles equitably among the participants to whom Transportation is provided. The provider is required (or it is the legal employer's responsibility under the Vendor Fiscal/Employer Agent (FMS) model) to track mileage, allocate a portion to each participant, and provide that information to the Care Manager for inclusion in the participant's service plan.

  Services must be delivered in a manner that supports the participant's communication needs including, but not limited to, age appropriate communication, translation services for participants that are of limited-English proficiency or who have other communication needs requiring translation, assistance with the provider's understanding and use of communication devices used by the participant.

- Public Transportation

  The utilization of Public Transportation promotes self-determination and is made available to participants as a cost-effective means of accessing services and activities. This service provides payment for the individual's use of public transportation.

The Care Manager will monitor this service quarterly and will provide ongoing assistance to the participant to identify alternative community-based sources of transportation. Consistent with other HCBS authorities in New York, all other options for transportation, such as informal supports, community services and public transportation, must be explored and utilized prior to requesting non-medical transportation. Individuals enrolled in residential services who receive transportation as part of the benefit will not be eligible for this 1915(i)-like service. Non-medical transportation is limited to no more than $2,000 per calendar year.

The state may employ its contracted regional transportation managers to oversee and approve this service working closely with individual care managers.

Individual Employment Support Services

Individual employment support services are individualized, person-centered services providing supports to participants who need ongoing support to learn a new job and maintain a job in a competitive employment or self-employment arrangement. Participants 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 participant's stated career objective and a career plan used to guide individual employment support.

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 persons without disabilities are employed, payment is made only for the adaptations, supervision, and training required by participants receiving waiver 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.

Services include:

Pre-vocational: Time-limited Services that prepare a participant for paid or unpaid employment. Services that provide learning and work experiences where the individual can develop general, non-job-task-specific strengths and skills that contribute to employability in paid employment in integrated community settings. Services are expected to occur over a defined period of time and with specific outcomes to be achieved, as determined by the individual and his/her service and supports planning team through an ongoing person-centered planning process.

Services include:

- Teaching such concepts as compliance, attendance, task completion, problem solving, and safety.
- Providing 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, socialization, daily living skills, communication, community living, social and cognitive skills.
- Gaining work-related experience considered crucial for job placement (e.g., time-limited unpaid internship).

Services do not include job/task oriented training.

Documentation is maintained 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.).

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

Transitional Employment: Services that strengthen the participant’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 individual supported employment, only when the person specifically chooses this service and may only be provided by clubhouse, recovery center or psychosocial club program.

Services include:

- Providing 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.
- Providing support to participants to gain skills to enable transition to integrated, competitive employment.
- Training activities provided in regular business, industry, and community settings.
- Promoting integration into the workplace and interaction between participants and people without disabilities in those workplaces.
- Providing on the job supports, 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.
- Providing services not specifically related to job skill training that enable the waiver participant to be successful in integrating in to the job setting.

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

Intensive Supported Employment: Services that assist consumers with serious mental illness in obtaining and keeping competitive employment. These services consist of intensive supports that enable participants to obtain and keep competitive employment at or above the minimum wage. This service will follow the evidence based principles of the Individual Placement and Support (IPS) model.

Services include:

- Personalized benefits counseling that assists clients in obtaining personalized information about their government entitlements.
- Assisting the participant to locate a job or develop a job on behalf of the participant via the use of individualized placement and support services that include rapid job search.
- Supporting the participant to establish or maintain self-employment, including home-based self-employment.
- Providing ongoing job-related discovery or assessment.
- Providing job placement, systematic job development, job coaching, negotiation with prospective employers, job analysis, job carving, 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.

The ongoing level of care criteria including service duration, intensity and effectiveness should be reviewed by the 1915(i) care manager and/or the MCO at least quarterly.

Ongoing Supported Employment: is conducted after a participant successfully obtains and becomes oriented to competitive and integrated employment. Ongoing follow-along is

support available for an indefinite period as needed by the participant to maintain their paid employment position.

Services include:

- Providing support in a variety of settings, particularly work sites where persons without disabilities are employed.
- Providing activities needed to sustain paid work by participants, including supervision and training.
- Providing reminders of effective workplace practices and reinforcement of skills gained during the period of intensive supported employment services.

Education Support Services

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 Office of Vocational Rehabilitation (OVR). Education Support Services may consist of general adult educational services including community college, university or other college-level courses, classes, tutoring to receive a Test Assessing Secondary Completion (TASC) diploma, and support to the participant to participate in an apprenticeship program. Participants authorized for Education Support Services must have an employment outcome or an outcome related to skill attainment or development which is documented in the service plan and is related to the Education Support Service need. Education Support services must be specified in the service plan as necessary to enable the participant to integrate more fully into the community and to ensure the health, welfare and safety of the participant. 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.

Ongoing Supported Education: is conducted after a participant 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.

Services include:

- Providing support in a variety of educational settings, such as classroom and test-taking environments.
- Providing cognitive remediation services to improve executive functioning abilities such as attention, organizing, planning and working memory.
- Providing advocacy support to obtain accommodations such as requesting extensions for assignments and different test-taking environments.

The hours for supported education are limited to no more than a total of 250 hours per year.

Self-Directed Services

Under self-directed Medicaid services, participants, or their representatives, if applicable, have employer and/or budget decision-making authority over certain services and take direct responsibility to manage their services with the assistance of a system of available supports. The self-directed service delivery model is an alternative to traditionally delivered and managed services where providers control hiring, supervision, and wages, such as an agency delivery model. Self-direction of services allows participants to have the responsibility for managing all aspects of service delivery within the context of a person-centered planning process.

Self-direction promotes personal choice and control over the delivery of waiver and state plan services, including who provides the services and how services are provided. Participants have both employer authority and budget authority. Employer authority affords participants the decision-making authority to recruit, hire, train and supervise the individuals who provide their services. Budget authority allows participants to have decision-making authority over how the Medicaid funds in a budget are spent such as wages paid and the number of hours worked.

New York State will be piloting self-direction of care in the mental health and substance use disorder area for the first three years of this demonstration amendment. New York State will work with stakeholders including peer organizations and managed care plans to design and pilot this initiative. The self-directed pilot will include the following elements:

- Person-centered planning process: The person and any collateral supports he or she identifies develop a plan that identifies the person's strengths, capacities, preferences, needs, and goals/outcomes. This plan should include contingency planning & an assessment of risks.
- Development of a service plan: The service plan describes the services and supports the person will use to meet the goals/outcomes he or she has identified in the person-centered plan.
- Individualized budget: Defines the amount of funds the person will control as part of the self-directed option. The method for calculating the scope of individual budgets is determined by the individual state offering the self-directed option.
- Information and awareness in support of self-direction: Supports must be in place that are designed to assist the individual in developing the plan, managing the plan, understanding how self-direction works, self-direction-specific supports such as a support broker and/or financial management services.
- Quality Assurance & Improvement: There must be a mechanism in place that provides continuous quality assurance and improvement, including monitoring and responding to serious incidents and monitoring performance measures and individual outcomes.

The following supports and services will be available to participants in the self-direction pilot:

- Support Broker Services: Medicaid requires that a support broker or counselor be available to assist in development, implementation, and monitoring of the self-directed services. The support broker is considered "an agent" of the individual and takes direction from the individual.
- Fiscal Management Services (FMS): FMS assists individuals with exercising budget authority. This is not a requirement but individuals often prefer to use the FMS for assistance with understanding billing and documentation, performing payroll and employer-related duties, purchasing approved goods & services, tracking and monitoring expenditures.