Date: July 2, 2018

To: Medicaid Managed Care Organizations with Health and Recovery Plans, HIV-Special Needs Plans serving HARP-Eligible Members, and Recovery Coordination Agencies

From: NYS Department of Health (DOH), Office of Mental Health (OMH), and Office of Alcohol and Substance Abuse Services (OASAS)

Re: Guidance on Documentation and Claiming for Recovery Coordination of Adult Behavioral Health (BH) Home and Community-Based Services (HCBS)

Background

Health and Recovery Plans (HARPs) and HIV/Special Needs Plans (HIV/SNPs) will utilize direct contractual arrangements with Recovery Coordination Agencies (RCAs) to help ensure access to Adult BH HCBS for members who are not enrolled in Health Home. Medicaid Managed Care (MMCOs) will directly reimburse contracted RCAs for the provision of Recovery Coordination services, including: HARP HCBS Assessment, Plan of Care Development – Initial, and Plan of Care Development – Ongoing. MMCOs will also provide for payments to RCAs to cover staff travel costs necessary to perform Recovery Coordination services.

This guidance document is intended to provide HARPs and HIV/SNPs – hereinafter "MMCOs" - and contracted RCAs with guidance on documentation and claiming requirements to support the accurate administration and reimbursement of Recovery Coordination services.

Recovery Coordination Services

The services provided by RCAs are referred to broadly as "Recovery Coordination services." Services consist of the following and are defined in more detail below:

A. HARP HCBS Assessment: NYS Eligibility Assessment
B. Plan of Care Development – Initial
C. Plan of Care Development – Ongoing

HARP HCBS Provider Travel Supplements are available to compensate for the cost of provider staff travel related to the delivery of assessments and/or Plan of Care (initial and ongoing) development.

Documentation of all Recovery Coordination services provided and related travel details must be maintained to support claiming for RCA services, and is subject to audit by the State.

Reimbursement rates for Recovery Coordination services are posted on the OMH website.

A. HARP HCBS Assessment: NYS Eligibility Assessment

Service Definition: This service consists of the completion of the NYS Eligibility Assessment for Adult BH HCBS.

The following requirements apply when claiming for Rate code 7778 "HARP HCBS Brief Assessment":

1. Must be completed face-to-face with the member.
2. Each member must be reassessed for BH HCBS eligibility annually, or more often as needed.
3. Can only be claimed once per diem
4. Can only be claimed three (3) times per every 365 days, per member.
5. Must be provided by qualified staff, as defined in the New York State "Policy for Improving Access to Adult Behavioral Health Home and Community Based Services (BH HCBS) for HARP and HARP-Eligible HIV Special Needs Plan Members Not Enrolled in Health Homes" (05/07/18).

Note: All NYS Eligibility Assessments must be completed in the online assessment platform, UAS-NY. Assessments not documented or finalized in the UAS-NY will NOT be reimbursed. See UAS NY Support for Users Guide for additional details for obtaining UAS-NY User Access and for completing the mandatory training.

B. Plan of Care Development – Initial

Service Definition: This service is a person-centered process that involves partnering with the member to identify their life role goal(s) and to plan for their behavioral health recovery using Adult BH HCBS. The Recovery Coordinator will work with the member and other key stakeholders (family, existing service providers, Adult BH HCBS services providers, and the MMCO) to complete the Adult BH HCBS Plan of Care.

"Plan of Care Development – Initial" includes all activities necessary to identify appropriate BH HCBS and develop the member's BH HCBS Plan of Care. Specific person-centered care planning activities include:

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

The mode of contact for Plan of Care Development activities may include: face-to-face meeting(s), electronic media or telephone calls. Contacts may occur with the member, family or other natural supports, Adult BH HCBS Providers, and/or other care providers involved in the development of the BH HCBS Plan of Care. Please see below for further details regarding face-to-face requirements.

It is recommended that the individual who has conducted the NYS Eligibility Assessment participates in the development of the Plan of Care.

The following requirements apply when claiming for rate code 7780 "Plan of Care Development - Initial":

1. The Plan of Care development process must include at least one (1) face-to-face contact with the member. Often, this will occur at the time of the member's review and approval (via signature) of the completed Plan of Care.
2. Rate code 7780 can only be claimed after the adult BH HCBS Plan of Care is complete. The Plan of Care is considered complete when federal requirements for the HCBS Plan of Care are included.

   ***Note*:** The specific BH HCBS type (e.g. Psychosocial Rehabilitation or Intensive Supported Employment) and provider agency must be clearly identified in the Plan of Care. The scope, duration, and frequency of authorized BH HCBS may be recorded in an HCBS Individual Service Plan (ISP) maintained by the HCBS Provider. The ISP is considered an attachment to the Plan of Care, and the service and goal(s) reflected should correspond to those identified in the Adult HCBS Plan of Care.
3. Can only be claimed for a maximum of one (1) time every 365 days per member.
4. Cannot be claimed for members enrolled in Health Home Care Management.

   Exception: A member may choose at any point to enroll in a Health Home, including during the initial Plan of Care Development process. When this occurs, the RCA may continue to work with the member to complete the initial Plan of Care and submit a claim for rate code 7780. The completed Plan of Care should then be shared with the Health Home Care Manager, and they will be responsible for ongoing care coordination and maintaining the BH HCBS Plan of Care.

C. Plan of Care Development – Ongoing

Service Definition: The full Plan of Care is reviewed at least annually and as needed when there is a significant change in the member's circumstances. This service may be provided any time subsequent updates or revisions are needed to the Adult BH HCBS Plan of Care. Such updates and revisions, made with the member's full knowledge and agreement, may include but are not limited to changes to any of the following:

- The member's person-centered life role goal,
- The member's residential setting, and/or
- The addition of new Adult BH HCBS or a change in Adult BH HCBS provider agencies.

Updates made to the scope, duration, and frequency of authorized BH HCBS may be recorded in the ISP maintained by the HCBS Provider.

"Plan of Care Development – Ongoing" includes all activities necessary to identify and make needed revisions to the member's BH HCBS Plan of Care. The type of activities and modes of contact described above for development of the Initial Plan of Care apply to ongoing development

of the Plan of Care as well. The RCA should document the work completed for the "Plan of Care Development – Ongoing" in increments of 15 minutes.

It is recommended that the individual who has conducted the NYS Eligibility Assessment participates in the completion in the plan of care and any subsequent changes to the Plan of Care.

The following requirements apply when claiming rate code 7781 "Plan of Care Development - Ongoing":

1. May only be used after the initial Plan of Care is developed and billed for, as described above.
2. Can only be claimed at a maximum of eight (8) units per day and 48 units per year, per fee schedule.
3. Cannot be claimed for members enrolled in Health Home Care Management.

This service is ***not*** intended to provide regular and routine care coordination activities. If a member presents with the need for ongoing care coordination of services outside of BH HCBS, the Recovery Coordinator should inform the MMCO so that the member can be enrolled in Health Home Care Management.

HARP HCBS Provider Travel Supplement (Transportation rates)

Staff Transportation reimbursement is available to compensate provider agencies for the cost of provider staff travel related to the delivery of BH HCBS. Transportation rates may be used as needed to support assessment and/or Plan of Care (initial and ongoing) development.

See Memo regarding Adult BH HCBS Staff Transportation (04/01/17) for more information including requirements for claiming these rates.

Recovery Coordination Services Claiming Information

Claims for the NYS Eligibility Assessment (rate code 7778), Plan of Care Development, Initial and On-going (rate codes 7780 and 7781), as well as the travel supplement claims (rate codes 7806 and 7807), must be submitted directly to a MMCO with whom the RCA is contracted and the assessed client is enrolled.

The MMCO shall support both hardcopy and electronic submission of claims and encounters for all claim types. The MMCO shall offer its providers an electronic payment option including a web-based claim submission system. Electronic claims will be submitted using the 837i (institutional) claim form. UB-04 (paper) claims will also be accepted by MMCOs.

The 837i (institutional) and UB-04 (paper) claim forms allow for use of rate codes which will inform the MMCO as to the type of behavioral health program submitting the claim and the service(s) being provided.

The MMCO must accept rate codes on all behavioral health outpatient claims.

Providers will enter the rate code in the header of the claim as a value code. This is done in the value code field by first typing in "24" and followed immediately with the appropriate four-digit rate

code. This is the standard mechanism for Medicaid Managed Care claims as part of the behavioral health benefit transition.

Billing requirements depend on the type of service provided; however, every electronic claim submitted will require at least the following:

- Use of the 837i claim form;
- Medicaid fee-for-service rate code (preceded by “24”);
- Valid procedure code(s);
- Procedure code modifiers (as needed); and
- Units of service.

The National Provider Identifier (NPI) is required in two (2) distinct fields on the institutional claim. The referring provider field can be filled using the program NPI.

Agencies will follow up with their contracted MMCO to determine the appropriate type of bill to submit on their claim. This will match how the MMCO has the agency identified in their own system.

The attending provider field (837I Loop 2310A NM109) should use the Unlicensed Practitioner ID, designated as (02249145) for an OASAS provider or (02249154) for OMH.

Further detail on proper claims submission can be found here.

Additional information regarding claim submission and fee schedules can be found here.

Questions

Provider questions regarding this guidance should be submitted to the OMH Division of Managed Care.