Bassett Healthcare Network
Community Health Navigation

HARP & HCBS Guide

What is HARP?

- **HARP (Health and Recovery Plans)** are specialized Medicaid insurance plans offered by **Managed Care Organizations (MCOs)** for persons with significant behavioral, mental health and substance abuse needs. HARP plans provide medical, mental health, and substance abuse services in an integrated way.

- Members are enrolled in HARP are eligible for additional services called HCBS Services.

"HARP- Enrolled" vs "HARP – Eligible"

- The **MCO** determines the member's eligibility for enrollment into a **HARP** plan based on assessed health diagnoses, care needs and billing/claims records for mental health, behavioral health and substance abuse services.

- Restriction/Exception Codes in Epaces show a Member's Current HARP status:

  - **H9:** HARP Eligible
    - The Member has been deemed eligible for the HARP Plan but is not yet enrolled in it.
    - HCBS Eligibility Assessments are NOT to be completed with HARP-Eligible Members
    - The Member can be enrolled in HARP by contacting the MCO.

  - **H1:** HARP Enrolled without HCBS
    - Member is enrolled in the HARP Plan.
    - H1 Members need to be assessed for HCBS Eligibility
    - Member will remain H1 if they decline the assessment or are found not eligible for HCBS after assessment

  - **H2:** HARP Enrolled with Tier 1 HCBS
    - Member is enrolled in HARP and has been assessed as eligible for Tier 1 HCBS Services
    - Members will remain H2 for one year after assessment regardless if they request or decline HCBS Services after assessment

  - **H3:** HARP Enrolled with Tier 2 HCBS
    - Member is enrolled in HARP and has been assessed as eligible for Tier 2 HCBS Services
    - Members will remain H3 for one year after assessment regardless if they request or decline HCBS Services after assessment

  - **H4:** HIV SNP HARP Enrolled without HCBS Eligibility

  - **H5:** HIV SNP HARP Enrolled with Tier 1 HCBS

  - **H6:** HIV SNP HARP Enrolled with Tier 1 HCBS

  - **H7:** Opted-out of HARP (Declined being enrolled in the HARP Plan)

  - **H8:** State Identified for HARP Assessment

What are HCBS?

- **HCBS (Home and Community Based Services)** are additional services available to members enrolled in a **HARP** managed care plan to assist with assessed functional needs. These services are provided in a home and community setting by State designated HCBS Providers, rather than at the site of the Provider.

Who is eligible for HCBS?

- A **Behavioral Health HCBS Eligibility Assessment** is completed with HARP members to determine eligibility for HCBS and determine the specific level and type of services available **(Tier 1 or Tier 2)**
  - Members may decline assessment
  - Members assessed as eligible for HCBS services may decline services
  - Members assessed as eligible and interested in HCBS services will work with their Care Manager to begin developing an HCBS Plan of Care, request service approval from the MCO & select from available HCBS Providers.

- HCBS Eligibility Assessments must be completed annually
  - Members who declined the assessment must be checked with yearly to see if they want to take the assessment or continue to decline
  - Members who are receiving HCBS services will lose services/have a gap in services if annual reassessment is not completed in time.

What are the available HCBS services?:

Tier 1:

- **Empowerment Services/Peer Supports**
- **Educational Support Services**
- **Individual Employment Support Services**
  - Prevocational Services (PV)
  - Transitional Employment Services (TE)
  - Intensive Supported Employment (ISE)
  - On-Going Supported Employment (OSE)

Tier 2: (Persons eligible for Tier 2 may receive all services in Tier 1 & 2)

- **Rehabilitation**
  - Psychosocial Rehabilitation (PSR)
  - Community Psychiatric Support and Treatment (CPST)
- **Crisis Respite**
  - Short-Term Crisis Respite (STCR)
  - Intensive Crisis Respite (ICR)
- **Habilitation** (H)
- **Support Services**
  - Family Support and Training (FST)
  - Non-Medical Transportation (NMT)

Resources for HARP-HCBS Education can be found on Bassett CHN Website

- DOH HARP-HCBS Brochure
- NYSMOH HARP & HCBS Videos
- MCTAC HARP & HCBS Videos

HCBS Tier 1 Services				
Service	**For Whom**	**Service Components**	**Member Says:**	**When NOT to refer Member:**
Empowerment Services/ Peer Supports (PS)	Members with a need and preference for Peer Support or persons with lived experience.	Advocacy, outreach and engagement, promote and educate on self-help tools, recovery support, and empowerment.	• I want support with my MH from someone who understands. • I don't have any friends and want to socialize with my peers. • I want to learn how to manage my symptoms. • You don't know what I'm going through. • I want to talk to someone that knows what I'm going through. • I need help with getting benefits. • I have too much free time, need recreational activities.	
Educational Support (ES)	Members who want to obtain formal education to become competitively employed.	Provides members with supports to obtain formal education/training to achieve employment goals.	• I want to go to school to become a vet. • I want to get my CNA certification so I can get a job. • I want to work but need my GED/TASC. • I'm interested in a trade program	Member is not interested in linking education goal to employment goal.
Prevocational (PV)	Members who want to prepare for employment but not ready to work today.	Provide member with non- job task specific strengths and soft skills (punctuality, communication with others, appropriate dress attire, working with others) that contribute to employability. Focus is on training.	• I want to work but I really don't think I can do it right now. • I want to work but I'm scared to go back to work. • I'm afraid no one will hire me because of my past criminal record.	
Transitional Employment (TE)	Members who want real-life work experience. Based on the clubhouse model.	Provide member with time-limited paid internship employment experience to help develop or strengthen work related soft skills.	• I would like to return to work but would like to gain more experience. • I want to try a new field.	Member is not interested/ ready to work right now.
Intensive Supported Employment (ISE)	Members who want to obtain competitive employment today but require supports to perform in a regular work setting. Based on evidence based practice.	Provides members with employment support to obtain a job placement such as job development, job coaching, negotiation with prospective employers, resume writing, benefits and financial management, etc	• I want a job asap. • I'm still using but I want to work. • I need money to support myself. • I'm tired of being on benefits. I need more money.	Member is not interested/ ready to work right now.
On-Going Supported Employment (OSE)	Members who want to retain competitive employment but have difficulty due to their behavioral health.	Provides members with supports to keep a job. Supports include: • benefits and financial management • negotiating with employer • conflict resolution • anger management • work/life balance • coping skills on the job	• I work long hours and I can't make it to my doctor's appointments. • How do I ask for a raise at my job? • I don't know if I should disclose? • I'm having a hard time working b/c my symptoms are bad. • I'm having trouble dealing with changes at work. • I am really frustrated with my boss.	Member is not employed in competitive employment.

HCBS Tier 2 Services

Service	For Whom?	Service Components	Member Says (Examples):	When NOT to refer Member
Psychosocial Rehabilitation (PSR)	Members who need to regain functional/ basic skills they once had but have lost.	A provider may closely work with the member on areas related with: • Relapse prevention planning • Socialization skill building • Wellness and self-management	• I used to be able to manage my money but I need help now that I'm on cash assistance. • I used to know how to travel on my own but since I've been in jail for the last 10 years, I forgot how to. Can someone help me with this? • I need help with staying sober. • I need help with dealing with anxiety. • I have days where I can't control my symptoms and it's affecting my life (daily living, relationships with family, normative roles).	
Community Psychiatric Support & Treatment (CPST)	Members who are disengaged from site-based services due to temporary physical setbacks (ie. Injury) or behavioral setbacks and need time limited treatment.	A clinical mobile treatment team works with member in his/her own home setting if he/she hasn't gotten connected to services like SU Outpatient Programs, Ongoing MH treatment or help client transitioning to ACT or PROS.	• I am waiting assignment to ACT team. • I would like help in reminding me to take my medications & how to take them. • I want to improve my MH. • I feel too depressed to go out to make it to my appointments.	Member is already engaged with outpatient MH/SU provider.
Short-Term Crisis Respite (STCR) (Available for all HARP Members. Does not need HCBS Eligibility or LOS Request)	Members who are experiencing challenges in daily life and are at risk for escalation of symptoms and feel that they cannot manage at home or community environment.	Offers to member a safe space when he/she needs to leave a stressful situation. Peer support and coordination with current providers. **Does not require HCBS LOS from HH CM & requires Provider Auth if stays are longer than 72 hours from HCBS provider	• I'm afraid to be alone. I'm feeling worse. I don't want to go to the hospital. • I need a break from my roommate. I'm afraid I am going to lose control.	
Intensive Crisis Respite (ICR) (Available for all HARP Members. Does not need HCBS Eligibility or LOS Request)	Members who are experiencing a behavioral health crisis including suicidality, homicidal ideation and acute escalation of MH symptoms	Help members to stay out of the hospital when they are having a crisis by providing a safe place to stay that can offer treatment. **Does not require HCBS LOS from HH CM & requires Provider Auth if stays are longer than 72 hours from HCBS provider	I'm feeling suicidal and have a plan but I'm not going to the hospital.	Member is at risk to self and/or others
Habilitation (H)	Members in need of functional and social skills building they never had or have had major challenges with attaining them .	A Provider may closely work with the member on areas related with: • Self-Care or ADL • learning how to follow instructions • relationship development • use of community resources • money and time management	• I would like to learn how to do laundry. • I would like to learn cooking skills. • I never had to budget my money. • I would like to learn how to organize my home better. • Why is my bill so high? • I need help opening my mail.	Member needs housing placement
Family Support & Training (FST)	Members who have need and preference for engagement with & education/training support for their family.	Provider provides training/ instruction on how member's family or significant others/ support system can support and help member in his/her recovery. Member does not need to be present for every session.	• My family/roommate does not understand my MH. • My family stopped talking to me when I started using. • I just finished rehab and my family is treating me differently.	Member is seeking therapy rather than information or is seeking parenting skills.
Non-Medical Transportation (NMT)	Members who need occasional transportation related to HCBS service goals.	Members may use Medicaid Taxi or receive Mileage Reimbursment for transporting themselves ($2,000 per year Limit)	I need transportation to HCBS goal related activities such as attending Job Fairs, Job Interviews, Meeting with School Admissions Counselor, etc.	Member needs regular/ongoing transportation

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Availability of HCBS Services in Bassett HH Region

HCBS Services	Herkimer	Chenango	Delaware	Otsego	Schoharie
Community Psychiatric Support & Treatment (CPST)					
Psychosocial Rehabilitation (PSR)	CFLR, CNYQ, KO	CCCC*,	RSS	NPCS RSS	RSS
Habilitation (H)	RCIL, CNYQ, KO	CCCC*,		NPCS	
Family Support and Training (FST)	CC/ARC-H, KO			NPCS ARC-H	SCCAP
Short Term Crisis Respite (STCR)					
Intensive Crisis Respite (ICR)					
Pre-vocational (PV)	CC/ARC-H, RCIL	STAR*,	RSS, STAR*	NPCS ARC-H	ARC-S
Transitional Employment (TE)			RSS	RSS	RSS
Intensive Supported Employment (ISE)	CC/ARC-H, RCIL	STAR*,	RSS STAR*	RSS ARC-H	RSS ARC-S
Ongoing Supported Employment (OSE)	CC/ARC-H, RCIL	STAR*,	RSS STAR*	RSS ARC-H	RSS ARC-S
Education Support Services (ES)	CC/ARC-H,			ARC-H	
Empowerment/ Peer Supports (PS)	KO, RCIL		RSS	RSS	*SCCAP*

Contact Information for HCBS Providers

Career Connections/Herkimer County Chapter, NYSARC, Inc. (CC/ARC-H)
Contact: Robin Mattox 125-127 E. Albany Street, Herkimer, NY 13350 O: (315) 574-7662 F: (315) 866-5738
Email: rmattox@archerkimer.org

Catholic Charities of Chenango County (CCCC) *Expected to begin providing services July 2018
Contact: Amanda Erickson 607-334-8244 aerickson@ccofcc.com

Center for Family Life and Recovery, Inc. (CFLR)
Contact: *Cassandra Sheets* 315-768-2645 csheets@cflrinc.org

Central New York Quest (CNYQ)
Contact: *Kristina Mancini* 315-732-3435 ext. 225 kristina@cnyquest.com

Kids Oneida, Inc. (KO)
Contact: *Lisa Tanner* 315-731-2637 ltanner@kidsoneida.org

Northeast Parent & Child Society (NPCS) & Parsons Child and Family Center (PCFC)
Contact: *Jacob Malison* 518-798-4496 ext. 5337 jacob.malison@neparentchild.org
Contact: Lori Favata 518-346-1285 ext. 7541 lori.favata@northernrivers.org

Rehabilitation Support Services (RSS)
Contact: Otsego & Schoharie- *Eric Mastrogiovanni* 607-433-0002 ext. 223 emastrogiovanni@rehab.org
Contact: Delaware- *Jayne Francisco 607-865-3158* jfrancisco@rehab.org

Resource Center for Independent Living, Inc. (RCIL)
Contact: *Mary K. Brognano* 315-797-4642 mbrognano@rcil.com

NYASRC, Inc., Schoharie County Chapter (ARC-S)
Contact: *Lauren Milavec* 518-295-8130 ext. 261 lmilavec@schohariearc.org

Schoharie Co. Community Action Program (SCCAP)
Contact: *Jodi Gregory* 518-234-0261 ext. 3023 jgregory@sccapinc.org

The Star Group (TSG) *Expected to begin providing services June 2018
Contact: Susan Wheeler 607-765-7827 swheelerstargrp@aol.com

Detailed Summary of each HCBS services:

Empowerment Services - Peer Supports (Tier 1)

Definition

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

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

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

Service Components

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

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

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

3. Self-help tools:
   - Assist selecting and utilizing self-directed recovery tools such as Wellness Recovery Action Plan (WRAP) or Individualized Recovery Plan
   - Assist selecting and utilizing the things that bring a sense of passion, purpose and meaning into his/her life and coaching the person as they identify barriers to engaging in these activities
   - Assist individuals to help connect to natural supports that enhance the quality and security of life
   - Connecting individuals to “warm lines”

- Connections to self-help groups in the community

4. Recovery Supports:
   - Recovery education and coaching for individuals and their family members.
   - One to one peer support
   - Person centered goal planning that incorporates life areas such as community connectedness, physical wellness, spirituality, employment, self-help
   - Assisting with skills development that guides people towards a more independent life

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

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

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Education Support Services (Tier 1)

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

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

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

Ongoing Supported Education: 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.

Service Components

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

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Pre-vocational Services (Tier 1)

Definition

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

Service Components

- Teaching concepts such as: work compliance, attendance, task completion, problem solving, and safety, and, if applicable, teach individuals how to identify obstacles to employment, obtain paperwork necessary for employment applications, and how to interact without the use of drugs with people who have not used drugs especially in the work place
- 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. This could include opening and maintaining a bank account for work-related direct deposit

- Gaining work-related experience considered crucial for job placement (e.g., volunteer work, time-limited unpaid internship) and career development. Services do not include development of job specific skills.

Transitional Employment (Tier 1)

This service is designed to 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, psychosocial club program certified provider or recovery center

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

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

Service Components

- Provide time-limited employment and on-the-job training in one or more integrated employment settings as an integral part of the individual's vocational rehabilitation growth.
- Provide support to 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 people without disabilities in those workplaces and other program participants if the TE placement is made for a group as well as individuals in recovery as well as those without disabling addiction or substance use disorders
- Provide Transitional Employment supports during placement. This support includes: initial and ongoing employment planning and advancement, employment assessment not otherwise covered in the annual career planning, job placement, job development, negotiation with prospective employers, job analysis, training and systematic instruction, job coaching, benefits supports, training, and planning transportation
- Training or referral to a training program
- Planning transportation
- Encourage and instill self-confidence to work in competitive employment
- ADL skills specific to the TE placement
- Teach Activities of Daily Living (ADL) skills specific to the Transitional Employment placement and may include appropriate dress, hygiene, walk, talk, and eye contact, money management, dealing with outstanding warrants, and legal history, time management, collection of work related documentation and credentials
- Offer Services not specifically related to job skill training that enable the waiver participant to be successful in integrating into the job setting
- Providing on the job supports, including:
    - On-site job training
    - Assisting the participant to develop natural supports in the workplace without the use of substances
    - Adopt an identity as a worker
    - Accept responsibility for decision
    - Examine past work experiences for failure and successes.
    - Consider potential for transferability of skills
    - Coordinate with employers and coworkers, as necessary, to accommodate the individual in meeting employment expectations, and addressing work related and personal issues as they arise

Intensive Supported Employment (ISE) (Tier 1)

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

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

Service Components

- Assist the participant to locate a job or develop a job on behalf of the individual via the use of individualized placement and support services that include rapid job search including acquisition of hard and soft skills to retain employment, training and systematic instruction, as well as providing support for the job application process such as resume writing, interviewing and application submission
- Support the individual to establish or maintain self-employment, including home-based self- employment
- Provide ongoing job related discovery and assessment
- Provide job placement, systematic job development, job coaching, negotiation with prospective employers, job analysis, job carving (creating, modifying, or customizing a community-based job such that it can be successfully performed by an individual on supported employment,) customize employment training and systematic instruction, benefits counseling support, training and planning, transportation, asset development and career advancement services, customized employment, and other workforce support services. Workforce support services include benefits counseling support (e.g., personalized benefits counseling that assists individuals in obtaining personalized information about their government entitlements), training and planning, transportation navigation, asset development and career advancement services.

Ongoing Supported Employment (Tier 1)

This service is provided 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. 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.

Service Components

- Providing support in a variety of settings, particularly work sites where persons without disabilities are employed:
  - Assists individuals to identify reasonable accommodations necessary to manage mental health symptoms that may emerge at work
  - Provides activities needed to retain paid work including job coaching and non-work task related training
  - Ongoing Supported Employment services may include assessment of issues and linkage/referral to other community resources as appropriate
- Providing activities needed to sustain paid work by participants, including supervision and training:
  - Provides supports to individuals who are currently employed in settings that are competitive and integrated
  - Assists individuals to establish positive workplace relationships, including interactions with supervisors, and co-workers
  - Helps individuals to build and sustain skills in the workplace, including time management, co-worker relationships, understanding supervisory roles and expectations, and accessing workplace supports, including EAP and job training
- Providing reminders of effective workplace practices and reinforcement of skills gained during the period of intensive supported employment services:
  - Assist individuals to manage mental health issues that may impact their ability to sustain employment

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

Psychosocial Rehabilitation (PSR) (Tier 2)

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

Service Components

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

- Rehabilitation, counseling, recovery activities, interventions and support with skills necessary for the individual to improve self-management of and reduce relapse to substance use, the negative effects of psychiatric , or emotional symptoms, that interfere with a person's daily living, and daily living skills that are critical to remaining in home, school, work, and community. Rehabilitation counseling and support necessary for the individual to implement learned skills so the person can remain in a natural community location including:
    - Personal autonomy: Learning to manage stress, unexpected daily events and disruptions, mental health symptoms, relapse triggers and cravings with confidence; develop and pursue leisure and recreational interests, manage free time comfortably; transportation navigation
    - Health: Developing constructive and comfortable interactions with health-care professionals, Relapse Prevention Planning (Individual Recovery Plan); managing chronic medical conditions, mental health symptoms and medications; establishing good health routines and practices
    - Social Skills: Engaging with people respectfully, appropriate eye contact, conversation skills, listening skills and advocacy skills
    - Wellness: meal planning, healthy shopping and meal preparation, nutrition awareness, exercise options
    - Personal care: grooming, maintaining living environment, managing finances and other independent living skills
- Rehabilitation counseling including recovery activities, interventions and support necessary for the individual to implement learned skills so the person can remain in a natural community location
- Assisting the individual with effectively learning adaptive behaviors responding to or avoiding identified precursors such as cravings or triggers that result in relapse or functional impairments

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

Community Psychiatric Support and Treatment (CPST) (Tier 2)

CPST includes time-limited goal-directed supports and solution-focused interventions intended to achieve identified person-centered goals or objectives as set forth in the individual's Plan of Care and CPST Individual Recovery Plan.
The following activities under CPST are designed to help persons with serious mental illness to achieve stability and functional improvement in the following areas: daily living, finances, housing, education, employment, personal recovery and/or resilience, family and interpersonal relationships and community integration. CPST is designed to provide mobile treatment and rehabilitation services to individuals who have difficulty engaging in site- based programs who can benefit from off-site rehabilitation or who have not been previously engaged in services, including those who had only partially benefited from traditional treatment or might benefit from more active involvement of their family of choice in their treatment.

Service Components:

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

- Assist the individual and family members or other collaterals 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 and their family supportive counseling, solution-focused interventions, emotional and behavioral management, and problem behavior analysis with the individual, with the goal of assisting the individual with social, interpersonal, self-care, daily living, and independent living skills to restore stability, to support functional gains and to adapt to community living

- Facilitate participation in and utilization of strengths based planning and treatments which include assisting the individual and family members or other collaterals with identifying strengths and needs, resources, natural supports, and developing goals and objectives to utilize personal strengths, resources, and natural supports to address functional deficits associated with their mental illness
- Assist the individual with effectively responding to or avoiding identified precursors or triggers that would risk their remaining in a natural community location, including assisting the individual and family members or other collaterals with identifying a potential psychiatric or personal crisis, developing a crisis management plan and/or as appropriate, seeking other supports to restore stability and functioning
- Provide ongoing rehabilitation support for individuals pursuing employment, housing, or education goals. Assist the individual with independent living skills to promote recovery and growth specific to managing their own home including managing their money, medications, and using community resources and other self-care requirements
- Implement interventions using evidence-based and best practice techniques, drawn from cognitive-behavioral therapy and other evidence-based psychotherapeutic interventions that ameliorate targeted symptoms and/or recover the person's capacity to cope with or prevent symptom interference with daily activities.

Habilitation (Tier 2)

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

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

Service Components

• Habilitation services may help participants develop skills necessary for community living and recovery with ongoing assessment of participants' functional status and development of rehabilitative goals, such as:

- Instruction in accessing and using community resources such as transportation, translation, and communication assistance as identified as a need in the plan of care and services to assist the participant in shopping and performing other necessary activities of community and civic life, including self-advocacy; for example, coordinating and helping to secure TTY services, language bank services, or other adaptive equipment needs
- Instruction in developing or maintaining financial stability and security (e.g., understanding budgets, managing money, and the right to manage their own money). Assistance in developing financial skills through instruction of budget development, money management skills, and self-direction with regards to managing own funds and relapse triggers. (Specifically, if a resident has a representative payee, one goal must be to develop skills to manage more independently)
- Skill training and hands-on assistance of instrumental activities of daily living, including assistance with shopping, cooking, cleaning, and other necessary activities of community and civic living (voting, civic engagement via community activities, volunteerism)

- Habilitation provides onsite modeling, training, and/or supervision to assist the participant in developing maximum independent functioning in community living activities. The on-site modeling, cueing, and /or instruction and support may assist participant in developing maximum independent problem-solving, interpersonal, communication, and coping skills, including relapse prevention planning, integration/adaptation to home/community, on-site symptom monitoring, and self -management of symptoms
- Facilitation of family reunification through coordination of family services as applicable and self- encourage the development of recovery support plans, i.e., medication compliance, ADL skills, and functional changes
- Housing preservation and advocacy training, including assistance with developing positive landlord-tenant relationships, and accessing appropriate legal aid services if needed including skills to successfully live with roommates
- Assistance with developing strategies and supportive interventions for avoiding the need for more intensive services such as inpatient detoxification, coordinating crisis services, and consulting with current service providers (including SUD providers, mental health providers, health care providers, family-friends-natural supports, parole-probation-drug courts, state vocational rehabilitation services and other stakeholders) to develop a plan for intervention
- Assistance with increasing social opportunities and developing social support skills that ameliorate life stressors resulting from the participant's disability and promote health, wellness and recovery. For example, helping a participant to connect to community-based organizations based on participants' identified interests that are available to the public and promote recovery and social integration
- Instruction in self-advocacy skills including activities designed to facilitate participants' ability to access social service systems (health care, substance abuse, employment, vocational rehabilitation, entitlements/benefits, self-help groups) and other recovery-oriented systems of care are included
- Instruction in developing strategies to manage trauma induced behaviors and/or PTSD as per a Trauma Informed Assessment

The cost of transportation provided by residential service providers to and from activities is included as a component within the rate of the residential service. Providers of residential services are responsible for the full range of transportation services needed by the participants they serve to participate in services and activities specified in their recovery-oriented service plan. This includes transportation to and from recovery-oriented services and employment services, as applicable.

Family Support and Training (Tier 2)

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

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

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

Service Components

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

Mobile Crisis Intervention (Tier 2)

Mobile Crisis Intervention 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. Mobile Crisis Intervention services are provided to a person who is experiencing or is at imminent risk of having a psychiatric crisis and are designed to interrupt and/or ameliorate a crisis including a preliminary assessment, immediate crisis resolution and de-escalation. Services will be geared towards preventing the occurrence of similar events in the future and keeping the person as connected as possible with environment/activities. The goals of Mobile Crisis Intervention services are engagement, symptom reduction, and stabilization. All activities must occur within the context of a potential or actual psychiatric crisis.

Service Components

Mobile Crisis Intervention services include the following components:

- A preliminary assessment of risk, mental status, medical stability and community tenure and the need for further evaluation or other mental health services. Includes contact with the consumer, family members, and/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
- Crisis resolution and consultation with the identified Medicaid eligible individual and the treatment provider
- Referral and linkage to appropriate Medicaid behavioral health community services to avoid more restrictive levels of treatment
- Linkage to Short Term Crisis Respite or Intensive Crisis Respite when clinically appropriate
- Includes contact with the client, family members, or other collateral sources 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
- Follow-up with the individual and the individuals' family/supportive network which could be provided by a Peer Specialist in order to confirm linkage to Care Coordination, outpatient treatment or other services as appropriate
- Consultation with a physician or other qualified providers to assist with the individual's specific crisis and plans for the individual's future.

Short-term Crisis Respite (Tier 2)

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

- A mental health or co-occurring diagnosis and are experiencing challenges in daily life that create imminent risk for an escalation of symptoms and/or a loss of adult role functioning but who do not pose an imminent risk to the safety of themselves or others
- A challenging emotional crisis occurs which the individual is unable to manage without intensive assistance and support
- When there is an indication that a person's symptoms are beginning to escalate
- Referrals to Crisis Respite may come from the emergency room, the community, self-referrals, a treatment team, or as part of a step-down plan from an inpatient setting. Crisis respite is provided in site-based residential settings. Crisis Respite is not intended as a substitute for permanent housing arrangements.

Service Components

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

- Onsite peer support during the respite stay
- Working with existing treatment providers
- Health and wellness coaching
- Relaxation techniques to help reduce stress, anxiety, emerging panic or feelings of losing control

- Coordinating with primary care, Health Home or other BH providers (on-site or through referrals)
- WRAP (Wellness Recovery Action Plan) planning
- Wellness activities
- Family support
- Conflict resolution
- Ongoing communication between the consumer, crisis respite staff, natural supports, and the individuals' established mental health providers to assure collaboration and continuity in managing the crisis situation and identifying subsequent support and service systems
- Collaboration with the individual, BH providers, and natural supports to make recommendations for modifications to the recipients' plan of care and treatment.
- At the conclusion of a Crisis Respite period, crisis respite staff, together with the individual and his or her established mental health providers, will make a determination as to the continuation of necessary care and make recommendations for modifications to the recipients' plan of care.

Admissions/Eligibility Criteria

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

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

Exclusions:

- Diagnosis of dementia, organic brain disorder or TBI
- Those with an acute medical condition requiring higher level of care
- At imminent risk to self or others that requires higher level of care
- Displays symptoms indicative of active engagement in substance use manifested in a physical dependence or results in aggressive or destructive be Does not have permanent housing or is homeless
- Is not willing or able to respect and follow the guest agreement during his/her stay
- Is not willing to sign necessary registration documentation
- Is not willing to participate in the wellness process during his/her stay

Limitations/Exclusions

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

Intensive Crisis Respite (BH HCBS Tier 2)

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

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

Service Components

- Comprehensive assessment including screening for physical health conditions
- Comprehensive risk assessment medication management
- Individual and group counseling
- Training in de-escalation strategies
- Relaxation techniques to help reduce stress, anxiety, panic or feelings of losing control
- Monitoring for high risk behavior
- Psychiatric evaluation for competency
- Linkage to resources and referrals to community-based mental health and substance abuse treatment.
- Peer support
- WRAP (Wellness Recovery Action Plan) planning
- Wellness activities
- Family support
- Engagement of Natural Supports
- Conflict resolution
- Hotline

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.

Admissions/Eligibility Criteria

- Individuals who may be a danger to self or others and are experiencing acute escalation of mental health symptoms and/or at imminent risk for loss of functional abilities, and raise safety concerns for themselves and others but can contract for safety.
- Experiencing symptoms beyond what can be managed in a short term crisis respite.
- Individual does not require inpatient admission or can be used as an alternative to inpatient admission if clinically indicated and person can contract for safety.
- Limitations/Exclusions
- 7 days maximum
- Intensive Crisis Respite services include a limit of 21 days per year. Individuals requiring Intensive Crisis Respite for longer periods than those specified may be evaluated on an individual basis and approved for greater length of stay based on medical necessity.
- Have an acute medical condition requiring higher level of care.

Non-Medical Transportation (BH HCBS Tier 2)

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.

Service Components

Transportation (per/mile) - This Transportation service is delivered by providers, family members, and other qualified, licensed drivers. Mileage 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 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 Case 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.

Replacement cards for lost or stolen cards or passes are to be approved by Case Manager. Participants must report lost or stolen card/pass and have written documentation to present.

Admissions/Eligibility Criteria
The type and amount of waiver transportation must be included in the approved Service Plan.

Limitations/Exclusions

- No more than $2,000 per calendar year for both public and mile reimbursement combined.
- Non-Medical Transportation will only be available for non-routine, time-limited services, not for ongoing treatment or services.
- All other options for transportation, such as informal supports, community services, and public transportation must be explored and utilized prior to requesting waiver transportation. This service is not intended to replace services provided by ACCES-VR, or any other existing provider, but compliment them.
- Individuals enrolled in residential services who receive transportation as part of the benefit will not be eligible for this HCBS

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

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

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

HCBS Clusters:

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

• Community Psychiatric Support and Treatment (CPST) and Psychosocial Rehabilitation (PSR)

• Crisis Services- Intensive Crisis Respite and Short-term Crisis Respite

• Employment Services- Pre-vocational, Transitional, Intensive Supported Employment, Ongoing Supported Employment

• Peer Supports may be used in conjunction with other HCBS