NEW YORK STATE | Department of Health | Office of Mental Health | Office of Alcoholism and Substance Abuse Services

Adult BH Home and Community Based Services (HCBS) Workflow

Review of updated guidance

Updated Guidance

- Updated guidance is effective 10/1/2017
- Guidance can be found at: BH HCBS Workflow Guidance
- Provides an updated workflow for Health Homes working to connect their HARP-enrolled and or HARP-eligible HIV SNP-enrolled members to Adult BH HCBS
- The previously issued workflow “Adult BH HCBS Plan of Care Approval Workflow for Individuals Enrolled in HARP or HIV SNPs” and follow-up Expedited Workflow guidance no longer apply, effective immediately

Summary of Changes

- Removal of requirements specific to the Full CMHA assessment
  - No longer required as of March 7, 2017

- Face-to-face requirement for NYS Eligibility Assessment

- Clarification language to address variety of feedback received

What is the workflow?

- ✓ The BH HCBS workflow is a process by which HARP members are connected to Adult BH HCBS.
- ✓ It is to be used by MCOs (HARPs), Health Homes and their downstream Care Management Agencies, and BH HCBS Providers
- ✓ The intent of the workflow is to allow for timely assessment and referral to BH HCBS for any HARP members interested in pursuing BH HCBS. It requires collaboration between HHCMs, MCOs and HCBS providers to develop a person-centered plan of care and to keep the member engaged throughout the process.
- ✓ All care managers serving HARP members MUST be trained on the workflow and the benefits of BH HCBS. Lead HHs, MCOs and/or CMA supervisors shall ensure adequate support and protocols are in place to ensure workflow requirements are met and that HARP members have access BH HCBS.

HCBS Workflow Timeframe

The overall timeframe allowed - from completing the NYS Eligibility Assessment to submitting a Plan of Care inclusive of BH HCBS to the MCO - shall be thirty (30) days (best practice) but no more than ninety (90) days from the individual's date of enrollment into Health Home, or from date of enrollment in the HARP or HIV SNP, whichever occurred later.

- BH HCBS Workflow Visual

1500- EA Understanding the Eligibility Assessment

- 1500 EA training is required for all NYS BH HCBS Assessors
- Training was updated as of 9/28/17
- As the full CMHA is no longer required, the training has been condensed to focus on items from the Eligibility Assessment (EA) only.
    - On average, completion time is around three hours
- This is a temporary training until the release of the updated and improved NYS EA Assessor Training targeted for a 2018 release.
- For those individuals who have already completed the full CMHA Assessor training, you will not be required to complete this interim EA assessor training additionally.
- Both the training course and Eligibility Assessments remain in the UAS platform

Eligibility Assessments

- NYS Eligibility Assessment is to be completed only for individuals who are *enrolled* in a HARP, or who are HARP-Eligible and enrolled in an HIV SNP

- The NYS Eligibility Assessment will determine eligibility for Adult BH HCBS :
  - Tier 1 Eligibility (employment, education, and peer support services only)
  - Tier 2 Eligibility (full array of BH HCBS)
  - No BH HCBS Eligibility

- Requirements to conduct the EA include:
  - Only performed by qualified HHCMs, as defined in the NYS BH HCBS Assessor requirements
  - Must be completed face-to-face

- Best practice for completing the EA is thirty (30) days of HH enrollment or when individual becomes enrolled in HARP or HIV SNP

Identifying HARP Enrolled

HHCM must verify current HARP or HIV SNP enrollment prior to completing the Eligibility Assessment.

HARP-enrolled individuals will be identified in EPACES/EMEDNY with one of the following restriction exception (RE) codes:

- H1 - HARP Enrolled without HCBS
- H4 - HIV SNP Enrolled, HARP Eligible without HCBS

Individuals with an H9 code are HARP eligible but pending enrollment in a HARP.

If the NYS Eligibility Assessment determines an individual is eligible for BH HCBS, one of the following RE codes will also display in EPACES:

- H2 - HARP enrolled with Tier 1 BH HCBS Eligibility
- H3 - HARP enrolled with Tier 2 BH HCBS eligibility
- H5 - HIV SNP HARP-eligible with Tier 1 BH HCBS eligibility, or
- H6 - HIV SNP HARP-eligible with Tier 2 BH HCBS eligibility

Individuals not pursing HCBS

There are circumstances that will result in the individual *not* pursuing BH HCBS after completing the NYS Eligibility Assessment.

1) Individual is found *not eligible* for BH HCBS based on the NYS Eligibility Assessment results
2) Individual is found eligible for BH HCBS but does not feel BH HCBS will help them reach their identified life role goal
3) Individual is found eligible for BH HCBS but chooses to remain in a State Plan service already meeting their need(s)
4) Individual is found eligible for BH HCBS and resides in a setting that is not considered home and community based

HHCMs will document in the individual's POC when and why a member will not pursue HCBS.

Individual's Recovery Goals

- Person-Centered Discussion
- How BH HCBS, State Plan, and/or Medical services may help achieve their goals
- It is important for a care manager to understand the full array of other programs and/or services, and when BH HCBS may be most beneficial for the individual
    - The HHCM shall help the individual make an informed choice about which available services best address their health needs and goals
- List of allowable State Plan and BH HCBS service combinations can be found at:
  HARP Mainstream Billing Manual

Level of Service Determination (LOSD) Request

- HHCM submits LOSD request to the MCO

- HHCM may make this request in either a written or verbal format, as agreed to by the MCO

- At minimum, the request shall include the following information:
  1) BH HCBS Eligibility results (indicating Tier 1 or Tier 2 eligibility)
  2) All services the individual currently receives
  3) The individual's recovery goal(s), and
  4) The specific BH HCBS recommended.

Level of Service Determination

- MCO reviews request and issues LOSD indicating their agreement with proposed BH HCBS
    - LOSD issued within 3 business days, but no more than 14 calendar days

- MCO may issue the LOSD in written or verbal format

- LOSD should not be mistaken for an *authorization* of services but rather the MCO's agreement that the level of BH HCBS proposed align with the individual's stated life and recovery goals

Referrals to BH HCBS

- Individuals must be given a choice of BH HCBS providers in the MCO network
  - HHCM can work with MCO to identify providers in the MCO's network
  - Choice must be documented in POC
  - Conflict-free approach

- HHCM should ensure referrals are made in a timely fashion. The HHCM should provide the BH HCBS provider with the following information:
  - Same information provided to the MCO for the LOSD request
  - LOSD issued by the MCO

- HHCM should work to keep individual engaged and ensure linkage to HCBS. HHCM can:
  - Send reminders for appointments
  - Offer transportation as needed.

- Non-Medical Transportation
  - Guidance for non-Medical transportation

Intake/Evaluation by BH HCBS Providers

- BH HCBS provider shall notify and provide the MCO with the date of their initial scheduled intake/evaluation appointment with the individual
    - Must notify MCO if the date changes

- BH HCBS Provider evaluates for scope, duration and frequency
    - Provider has up to three (3) visits with the individual within 14 days of initial visit

    - If more time or visits are needed, the BH HCBS provider must notify the MCO and request authorization for additional time/visits needed.

BH HCBS Authorization of Ongoing BH HCBS

- BH HCBS provider completes intake/evaluation
  - BH HCBS provider will recommend scope, duration and frequency
  - To request MCO authorization, BH HCBS provider must submit "Adult Behavioral Health Home and Community Based Services (BH HCBS): Prior and/or Continuing Authorization Request Form"

- MCO will review the form and issue a determination
  - Determination issued within 3 business days, but no more than 14 calendar days
  - If the MCO denies or partially approves the services requested by the BH HCBS provider, the MCO must issue an initial adverse determination, with applicable appeal and fair hearing rights

- Provider sends authorized scope, duration and frequency of BH HCBS to the HHCM.

Completion of the BH HCBS Plan of Care

- POC is the framework for communicating the individual's service needs between the HHCM, the BH HCBS provider and the MCO
    - The HHCM "holds" the overall POC
- Driven by the individual's life and recovery goal(s)
- Includes BH HCBS, behavioral health, medical, community and natural supports
- Fluid document
- Development of the POC should involve family, supportive friends, providers, and MCO
- Must include federal requirements for BH HCBS. BH HCBS Plan of Care Federal Rules and Regulations Checklist

Completion of the BH HCBS Plan of Care

- Health Homes can incorporate the BH HCBS federal requirements into their existing Health Home POCs
- Health Homes could use the State-issued BH HCBS Plan of Care Template
    - A more simplified POC template will be made available in the near future
- The individual and the BH HCBS providers must sign the POC
    - All other providers should sign as well. However, inability to obtain these provider signatures will not impact the MCO Level of Service Determination, authorization, or provision of BH HCBS.
- Should be completed within 90 days of HH enrollment or when individual becomes enrolled in HARP or HIV SNP

Plan of Care submitted to the MCO

- HHCM will send the completed POC to the MCO

- MCO monitors for:
    - completion of the complete Plan of Care within 90 days
    - confirms that it meets all federal HCBS requirements

- MCOs may work with Health Homes and/or CMAs directly to help improve any quality issues, such as unnecessarily delayed assessments or incomplete POCs

- MCOs may request the POC for any of their members as deemed clinically necessary.

Ongoing Monitoring of the POC

- POC shall be updated to reflect changes in:
  - The individual's needs and goals
  - BH HCBS eligibility
  - BH HCBS
    - *When a new type of BH HCBS needs to be added to the POC, a new Level of Service Determination request should be submitted to the MCO*
- HHCM shall share revised POCs with the MCO

Reassessment

- NYS Eligibility Assessment is valid for the period of one (1) year from the date of completion
    - HHCM will reassess the individual at least annually or, after a significant change in the individual's condition *warrants a change be made to the individual's Plan of Care*

- Re-assessment is required for all HARP members and HARP-eligible HIV SNP members
    - Including those previously deemed not eligible for BH HCBS at their last assessment

Important links

- BH HCBS Workflow Guidance
- BH HCBS Workflow Visual
- Guidance for non-Medical transportation
- Adult Behavioral Health Home and Community Based Services (BH HCBS): Prior and/or Continuing Authorization Request Form
- BH HCBS Plan of Care Template
- BH HCBS Plan of Care Federal Rules and Regulations Checklist
- HARP Mainstream Billing Manual
- Medicaid Managed Care Model Contract
- Assisting Health and Recovery Plan (HARP) Eligible Individuals Enroll in HARP

Questions?

If you have any questions on the process, please contact Nicole Haggerty at NYS OMH Nicole.haggerty@omh.ny.gov or Peggy Elmer at NYS DOH peggy.elmer@health.ny.gov.

Thank You!