ADMINISTRATION OF THE NYS ELIGIBILITY ASSESSMENT FOR BEHAVIORAL HEALTH HOME AND COMMUNITY BASED SERVICES (BH HCBS) AND THE NYS COMMUNITY MENTAL HEALTH ASSESSMENT

Final As Of 01/14/2016

- Health Homes should continue to prioritize Health Home enrollment for individuals who are identified/flagged in the Health Home tracking system as HARP eligible.

- Health Home care managers and other entities who may be designated by the State will perform assessments to:
  1) determine if ***HARP enrolled or HARP-eligible enrolled in an HIV SNP (for the purpose of this billing guidance both types of plans will be referred to as HARPs)*** Health Home members are eligible for Behavioral Health Home and Community Based Services (BH HCBS) (The NYS Eligibility Assessment), and
  2) if eligible for BH HCBS, complete the NYS Community Mental Health Assessment (CMHA).

Verifying Eligibility to Conduct Assessment: ***EPACES/EMEDNY.***

Prior to conducting the Eligibility Assessment or the CMHA, the assessor must verify the individual is ***enrolled in a HARP*** *through EPACES/EMEDNY. More information on how to check for Medicaid eligibility can be found at the following links:*

https://www.emedny.org/selfhelp/ePACES/ePACES_Help.pdf
https://www.emedny.org/hipaa/QuickRefDocs/ePACES-Enrollment_Overview.pdf

HARP enrolled individuals will be identified with Restriction Exception (RE) codes H1 (HARP Enrolled without HBCS) or H4 (SNP HARP Eligible without HBCS) and be enrolled with one of the following Managed Care Plans:

Provider Name	Provider ID
AMERIGROUP NEW YORK LLC	04004537
AMIDA CARE INC	02191582
HEALTH INSURANCE PLAN OF GREATER NE	04082293
HEALTHFIRST PHSP INC HARP	04003696
METROPLUS HEALTH PLAN INC	04053201
METROPLUS PARTNERSHIP CARE SN	02191362
NEW YORK STATE CATHOLIC HEALTH PLAN	04004486
UNITEDHEALTHCARE OF NEW YORK	04054091
VNS CHOICE SELECT HEALTH SNP	03420871

- ***The results of the Eligibility Assessment may trigger the addition of RE codes:***
    - ***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).***

- ***Accuracy in the manual input of data into the CMHA is critical for care planning and billing (see below for more information on billing). For Example, if the incorrect Health Home name is reported in the assessment, the HARP will reimburse the wrong Health Home. Assessing entities should have procedures in place to ensure that the Health Home information entered into the UAS for the assessment is correct.***

Use of CMHA for Non-HARP Enrollees

- Care managers that choose to use the CMHA for care planning purposes for members that are not enrolled in a HARP may do so, but **payment may not be made for CMHAs performed on members that are NOT enrolled in a HARP.** Care managers should note that the CMHA does not assess for physical health needs and thus may not provide all the information required to develop comprehensive plan of care.

- Assessments ***should not*** be conducted to determine ***HARP eligibility*** at this time.

Timelines for Assessments

- As provided in the "Health Home Standards and Requirements for Health Homes, Care Management Providers and Managed Care Organizations (As of October 5, 2015) (referred to herein as the "Standards Document") http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/hh_mco_cm_standards.pdf, Health Home care managers should make every effort to complete the Eligibility Assessment to determine BH HCBS eligibility within 10 days, but not longer than 21 days of an individual's assignment to the care management provider. As a best practice the entire assessment process, including both the Eligibility Assessment and the CMHA, should be completed within 30 days of the individual's enrollment in a State-designated Health Home or other State-designated entity, but in no case shall such process be completed more than 90 days after such enrollment unless such timeframe is extended by the State as necessary for a limited period to manage the large number of assessments anticipated during the initial HARP enrollment period. For HARP enrolled individuals who are already enrolled in a Health Home, Health Homes should prioritize completing the Eligibility Assessment for these individuals; and as a best practice for individuals who are

determined to be BH HCBS eligible, complete the CMHA within 30 days of the date the Eligibility Assessment was conducted.

- Health Home care managers will perform BH HCBS reassessments at least annually and when there is a significant change in status for HARP members receiving BH HCBS.

- As a best practice, Health Home care managers are encouraged to complete the CMHA in one day.

- Assessors need to sign the finalized assessment. Only signed/finalized assessments are considered valid.

<u>Qualifications for Conducting Assessments</u>

- Health Home care managers and/or other entities (if designated by the State) who perform Eligibility Assessments or CMHAs must meet the following qualifications:

a) Education:
  i) A bachelor's degree in any of the following: child and family studies, community mental health, counseling, education, nursing, occupational therapy, physical therapy, psychology, recreation, recreational therapy, rehabilitation, social work, sociology, or speech and hearing; OR
  ii) NYS licensure and current registration as a Registered Nurse and a bachelor's degree; OR
  iii) A Bachelor's level education or higher in any field with five years of experience working directly with persons with behavioral health diagnoses; OR
  iv) A Credentialed Alcoholism and Substance Abuse Counselor (CASAC).

b) Experience:
  i) Two years' experience (a Master's degree in a related field may substitute for up to one year of experience) either:
    A) Providing direct services to persons with serious mental illness or developmental disabilities, or alcohol and/or substance abuse; OR
    B) Linking persons who have serious mental illness or developmental disabilities, or alcohol and/or substance abuse to a broad range of services essential to successfully living in a community setting.

c) Training and Supervision:
  i) Specific mandated training for the designated NYS Community Mental Health Assessment (CMHA) tool, the array of services and supports available, and the person-centered service planning process. Training in assessment of individuals whose condition may trigger a need for BH HCBS and other

supports, and an ongoing knowledge of current best practices to improve health and quality of life.

ii) Must have supervision from a licensed clinician with prior experience in a behavioral health clinical or care management supervisory capacity.

Note: The State may waive such qualifications on a selected basis and under circumstances it deems appropriate, which may include care manager capacity issues.

Developing the Plan of Care

- Health Homes must prepare plans of care (POC) for HARP members receiving BH HCBS that meet the BH HCBS POC requirements established by the Centers for Medicare and Medicaid Services (CMS).

- *The State has provided a template that includes all the elements required to be in a POC that meets the HCBS requirements established by CMS. As applicable, Health Homes may incorporate these elements into their current care management software or may attach/upload the completed template to their care management software. Health Homes must continue to meet the Health Information Technology requirements for Health Homes included in the Standards Document. Please see the following documents to view the CMS required POC elements:*
  - BH HCBS Plan of Care Template
  - BH HCBS Plan of Care Federal Rules and Regulations Checklist

- For individuals enrolled in a HARP, the POC must also include the following specific elements:
  a) Documentation of results of the Eligibility Assessment (e.g., Not Eligible, Eligible for Tier 1 BH HCBS only, Eligible for Tier 1 and Tier 2 BH HCBS);
  b) For individuals eligible to receive BH HCBS, a Summary of the CMHA
  c) For individuals eligible to receive BH HCBS, recommended BH HCBS that target the individual's identified goals, preferences, and needs.

- HARPs are required to approve the BH HCBS POC. *Please see the Adult BH HCBS Plan of Care Approval Workflow*

- A POC for ***BH HCBS*** is not required in instances where an enrollee:
  a) Is determined to be ineligible for BH HCBS; or
  b) Declines BH HCBS offered through the assessment process.

However, a comprehensive, person-centered POC that meets the requirements included in the Health Home Standards Document must be completed for all other non-BH HCBS services and supports required by the individual. At this time there is no requirement for MCOs to approve non-BH HCBS POC prepared by Health Home care managers. However, MCOs may request the POC for any member as deemed clinically necessary.

BILLING FOR THE NYS ELIGIBILITY ASSESSMENT AND THE NYS COMMUNITY MENTAL HEALTH ASSESSMENT

Prior to conducting the Eligibility Assessment and the CMHA for an individual flagged as HARP eligible, the assessor must verify the member is HARP ***enrolled through EPACES/EMEDNY. For the purpose of this billing guidance both HARP and HIV SNP plans will be referred to as HARPs. HARP enrolled members will be identified with Restriction Exception (RE) codes H1 (HARP Enrolled w/o BH HCBS) or H4 (SNP HARP Eligible w/o BH HCBS) and enrolled in one of the plans listed below:***

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- For Health Home enrolled members payments for the assessments will flow from the HARP, to the Health Home, and then to the assessing entity.

- Data files that include cumulative data on the Eligibility Assessments and the CMHAs that were completed for HARP members will be provided to the HARPs on a bi- weekly basis. Plans may use the information in these data files to bill Medicaid directly and send the payment to the Health Home that is named in the data file. Similar data files will be provided on a bi-weekly basis to Health Homes for their Health Home members.

- The data will be provided by the SDOH to the designated **HARP contact and the Health Home contact** using the secure file transfer application in HCS.

- If the Eligibility Assessment determines an individual is eligible for BH HCBS and a CMHA was completed on the same day, the data file will contain two rows for the member – one row that lists the Eligibility Assessment and another row that lists the CMHA.

- If the member was determined by the Eligibility Assessment to be BH HCBS eligible and the CMHA does not appear in the data file, it may mean that the assessor will perform the CMHA on a future date. A subsequent data file will list the CMHA for the

HARP member after the assessment has been signed and finalized by the assessing entity.

- In cases where both the Eligibility Assessment and the CMHA are conducted on a HARP member, the HARP may only bill Medicaid for the CMHA.

- In cases where it is determined by the Eligibility Assessment that a HARP enrolled member is not eligible for BH HCBS, or declines to have a CMHA conducted (the declination of the CMHA by the member should be documented in the POC), the HARP may only bill Medicaid for the Eligibility Assessment. In these cases the data file will not indicate that the CMHA will be completed, therefore, HARPs should wait at least 30 days after the date the Eligibility Assessment is completed before billing Medicaid for the Eligibility Assessment. If there is communication between the HARP, Health Home, and the assessing entity that a CMHA is **not** going to be completed for a member then the HARP can bill Medicaid for the Eligibility Assessment.

- The rate codes for the Eligibility Assessment and the CMHA are loaded to the Managed Care Plan rate profiles.

- The remittance for assessments completed that are sent from the HARP to the Health Home should include at least:
  Name of member assessed
  Medicaid Member id
  Type of assessment completed (Eligibility/CMHA)
  Amount of payment
  Name of assessing entity

- Health Homes will receive assessment data files for their members on a bi-weekly basis. Health Homes may use the data files to reconcile the remittances they receive from the HARPS. Health Homes will then pass the remittance received from the HARP to the assessing entity that completed the assessment.

- HARPs and Health Homes can log into the HCS, launch the Community Mental Health Application, and view both the Eligibility Assessment and CMHA.

- Eligibility assessments are limited to three per member per calendar year and CMHA are limited to two per calendar year.

Please refer to the links below for additional information on:

- Community Mental Health Assessment:
  http://www.omh.ny.gov/omhweb/bho/interrai.html

- Rate Code Information: Assessing entities will bill the plan for the provision of the HARP BH HCBS Eligibility Assessment or CMHA using the coding combinations identified on http://www.omh.ny.gov/omhweb/bho/fee-schedule.xlsx