



HCBS Workflow FAQ

NYS Eligibility Assessment (EA)

- 1) Does the Eligibility Assessment take the place of the Health Home Comprehensive Assessment?

A: No. The HH Comprehensive Assessment is required for all HH members, while the NYS Eligibility Assessment is additionally required for all HARP members and only determines eligibility for Adult Behavioral Health Home and Community Based Services (BH HCBS). However, the State strongly encourages CMAs to streamline and minimize assessment burden as much as possible by performing the Eligibility Assessment in alignment with the HH Comprehensive Assessment process.

- 2) Are there situations where the Eligibility Assessment could be completed over the phone?

A: The NYS Eligibility Assessment must be completed face-to-face. However, the State understands that the Eligibility Assessment may take more than one session to complete. If part of the process is face-to-face, then the requirement is met.

- 3) Is the DOH-5230 (Functional Assessment Consent) required in order to complete the Eligibility Assessment?

A: Consent must be obtained from the member prior to completing the EA. The DOH-5230 can be used to document consent was obtained. Please note that this consent form is separate from the DOH-5055 Health Home Patient Information Sharing Consent.

- 4) Is there a requirement to complete the DOH-5230 when an individual declines the Eligibility Assessment?

A: No. If no information is being entered in to the UAS-NY assessment platform, then consent is not applicable.

- 5) What is the timeline if the care management agency has just become trained to complete assessments on HARP eligible clients?

A: Best practice for completing the NYS Eligibility assessment is thirty (30) days of Health Home enrollment, or from HARP- or HIV/SNP-enrollment, whichever occurred later. The HHCM has the option to initiate the NYS Eligibility Assessment as soon as they receive a new member assignment.

- 6) How should a HHCM document when an individual refuses the Eligibility Assessment?

A: If the individual declines the NYS Eligibility Assessment, this information should be documented in the individual's Plan of Care (POC).

- 7) Is the Eligibility Assessment required for individuals who decline BH HCBS services?

A: The Eligibility Assessment and annual re-assessment is required for all HARP members and HARP-eligible HIV SNP members.

8) If an individual refuses HCBS services, how does the HHCM document the refusal?

A: In the future, UAS-NY will have functionality to document when an individual is eligible but refuses HCBS. In the meantime, the HHCM will document in the POC.

9) Can individuals who reside in Adult Homes or Group Homes receive HCBS?

A: With the exception of crisis respite, individuals residing in these settings can not receive BH HCBS. Please see question 10 for more information on completing the Eligibility Assessment for individuals in these settings.

10) Should Eligibility Assessments be completed for individuals who live in Adult Homes or Group Homes that make them ineligible for HCBS?

A: The requirement is for all HARP-enrolled individuals to be assessed annually for HCBS eligibility, regardless of their current setting. In some cases, the assessment and ensuing discussion surrounding BH HCBS may reveal new opportunities for the individual to transition into more independent housing with the supports of BH HCBS. For those found eligible for HCBS but decide they are not ready or interested in transitioning out of the supervised setting any time soon, the care manager will just document that in the member's POC as the reason for not moving forward with BH HCBS referrals.

11) Can a CMA bill for completing an annual Eligibility Assessment?

A: Yes. For more information on billing please see:

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/community_mental_health_assessments_billing_guidance.htm

12) We have had several ACT providers stating they have no idea how or who should administer the brief assessment. Where can we steer these providers?

A: Guidance can be found here:

https://my.omh.ny.gov/analyticsRes1/files/act/ACT_Guidance_HARP.pdf

13) Will the "Manager" reports for NYS EA be fixed so that we can track our completed Eligibility Assessments in aggregate?

A: In the future, UAS-NY will have functionality to provide a variety of Manager reports including an aggregate report on Eligibility Assessments.

Level of Service Determinations (LOSD)

1) Does the member need to be present when the HH CM sends the LOSD request to the MCO?

A: No

2) When requesting a Level of Service Determination for HCBS, sometimes the MCO may ask for additional information beyond the four (4) items required in State guidance. For example, based on clinical information provided, an MCO might ask for medication, physical health, or BH history. Is this appropriate for MCOs to ask?

A: The requirements stated in the guidance covers all necessary information for issuing an LOSD for BH HCBS. Any additional information requested by the MCO must not result in unnecessary delays to this process or the CM's ability to make timely referrals to HCBS.

3) Should an MCO reject a Plan of Care if HCBS provider signatures are missing?

A: MCO's should work with Health Homes, CMAs and/or HCBS providers to ensure all indicate their agreement with the HCBS POC, as evidenced by their signature. However, inability to obtain provider signatures shall not impact the issuance of Level of Service Determinations, authorizations, or provision of BH HCBS. If providers are refusing to sign the POC, or if the individual chooses not to share their POC with certain providers, the care manager should document this in the POC.

4) When an MCO issues an LOSD verbally (over the phone), how should this be documented?

A: Verbal interactions with other members of the individual's care team, including the MCO, should be documented in the member's care management record.

5) Who is responsible to communicate the LOSD information to the HCBS provider once selected by the patient to schedule an initial appointment?

A: With proper consent, the HHCM makes the referral to the HCBS provider(s) selected by the member. The HHCM shall send the Level of Service Determination, along with all information previously provided to the MCO for the Level of Service Determination request, to the BH HCBS provider(s).

Plan of Care

1) Can you provide an electronic (editable) version of the State issued POC? The current one is in PDF format with a link to get an electronic version, but the link doesn't work.

A: The Health Home is required to provide a POC that is inclusive of HCBS requirements in the Electronic Health Record. We recommend following up with your Health Home(s). In the near future, the State will be sharing an updated POC template.

2) Do all BH HCBS providers need to sign the POC with the member and HHCM all present at the same time?

A: No

3) In which section of the POC does the HCBS provider sign?

A: Please check with your Health Home if not sure where provider signatures are located in the POC. Provider signatures just need to be included in the POC to show their agreement with the POC.

4) Is the HCBS Plan of Care done every 6 months or annually?

A: The POC is a fluid document that will change and evolve over time as the individual's needs are realized and new services and supports are identified. Please refer to question 9 for information on an integrated Plan of Care.

5) Does the HCBS POC need to be completed if the member does not want HCBS services, or can we just note the reason why they declined services in the Health Home POC?

A: The State requires that the POC include additional HCBS federal requirements when a HARP member pursues HCBS services. The State encourages Health Homes to

implement one single POC that includes HCBS requirements, but for HHs who may have separate templates for HH POC and HCBS POC, care managers should refer to the Health Home policy and procedures for the POC.

- 6) The POC template that the State provided does not list a space to show choice of providers. Where should this information be documented?
A: The POC should include affirmation from the member stating that they selected the providers listed in the POC, after being given a choice in providers by their HHCM and/or MCO. The State-issued POC template provides a place to document this in the “Recipient Rights Section.”
- 7) Do all BH HCBS providers need to sign the final POC submitted to the MCO?
A: The HHCM shall ensure that all BH HCBS providers listed in the Plan of Care sign the POC.
- 8) If a member is requesting several HCBS services, and then after the evaluation the member decides on only one service, does the POC need to be updated reflecting that change?
A: Yes
- 9) Is the Health Home Plan of Care required in addition to the BH HCBS Plan of Care?
A: The State strongly recommends that all HHs work towards an integrated POC that covers all aspects of the person’s needs/services inclusive of BH HCBS requirements, as opposed to a separate POC for HH and BH HCBS. An updated BH HCBS POC template will also be released by the State, in the near future, to provide HHs an example of an integrated POC would look like.
- 10) What if the member has not consented to have the MCO included on the consent form and there is no BAA with the CMA? How can the CMA communicate with the MCO?
A: State-issued memo regarding this issue to follow.

Referrals to HCBS

- 1) Where can we find resources to explain the benefits of BH HCBS services to members?
A: Resources will be available for order in the future from OMH.
- 2) When referring the individual to an BH HCBS provider, is the entire Eligibility Assessment sent?
A: BH HCBS. BH HCBS Workflow guidance requires the CM to include the individual’s EA results with a referral to BH HCBS (e.g., Eligibility Summary Report from the assessment platform). If the BH HCBS provider requests the entire Eligibility Assessment, the HHCM may provide the assessment with the individual’s consent. However, requesting and obtaining the Eligibility Assessment should not delay the referral process for an individual to receive
- 3) Does a release need to be signed (or the BH HCBS provider added to the HH DOH-5055) before the CMA makes the referral to the HCBS provider?
A: With proper consent, the HHCM shall send the Level of Service Determination, along with all information previously provided to the MCO for the Level of Service Determination request to the BH HCBS provider(s).

4) Can we have a link for updated BH HCBS Providers per county?

A: The BH HCBS provider list can be found at:

<https://www.omh.ny.gov/omhweb/bho/provider-designation.html>

5) I believe BH HCBS providers are locked into counties they are serving. Is a person restricted to only receive services in the county they reside? Or can they travel to other counties for services if wanted?

A: BH HCBS providers are designated by county based on the sites listed on their application. Because BH HCBS are intended to be home- and community-based, it is expected that BH HCBS providers would be traveling to the individual and not the other way around. For this reason, BH HCBS providers must obtain designation to provide services in each county they intend to serve. If a provider wishes to expand to serve other counties, they should contact OMH at omh.sm.co.hcbs-application@omh.ny.gov.

6) What is the expected timeframe for BH HCBS Providers to complete the initial visit after receipt of referral?

A: The provider should schedule the intake upon receipt of the referral. The provider has up to three (3) visits with the individual within 14 days of the initial visit to evaluate for scope, duration, and frequency. For more information, please refer to the [HCBS Workflow](#) guidance.

7) Do you have any recommendations for BH HCBS providers that require members to travel to their organization, in order to receive BH HCBS?

A: The intent of BH HCBS is to provide services in the home and community. Therefore, the location where services are provided should best meet the needs of the individual.

Annual Reassessment for HCBS Eligibility

1) Is the MCO expected to track that an Eligibility Assessment has been completed on a yearly basis?

A: Yes. The MCO will monitor for timely completion of the NYS Eligibility Assessment and POC for BH HCBS, and may work with Health Homes to improve any quality issues.

3) Will the State be able to provide reports of members that are due for re-assessment?

A: Reporting functionality to track re-assessments will be made available in the UAS in the future. In the meantime, providers should work with their lead HH's on how best to track re-assessment due dates.

Miscellaneous

1) If a person is HARP-enrolled and HH-enrolled but does not pursue BH HCBS, can you bill for the Health Home-HARP service rate?

A: Yes

2) Can a HARP enrolled individual participate in BH HCBS if they are not enrolled in a Health Home?

A: At this time, a HARP Enrolled individual can be assessed by a HHCM or State Designated Entity (SDE) identified by an MCO for the BH HCBS eligibility assessment and BH HCBS referral process. HARP enrolled individuals do not need to be enrolled in a HH to receive HCBS. However, members may benefit from enhanced care coordination and integrated care planning services designed to promote ongoing engagement in care through the HH.

- 3) Have any best practices been identified to document a single BH HCBS provider for multiple BH HCBS services? For example, Certified Peer Jane Smith is providing Empowerment services and Habilitation services for member John Doe.

A: Each Adult BH HCBS provider is responsible for employing qualified staff for each of their designated services. In many cases, individual staff members are qualified and trained to provide more than one BH HCBS (e.g. Education Support Services and the Employment services, or PSR and Habilitation). If an agency does use staff to provide multiple services, there should be very clear and concise training around the service definitions and components for each service in order to ensure accurate documentation and billing.

- 4) Is there anything in place for clients whose status is changing from enrolled (H1) to eligible (H9). While they are in the process of getting services, or scheduled for their assessment.

A: If the individual is not HARP-enrolled, they would not be covered for HCBS services.

- 5) Are there any updates on whether or not HARP enrollment will be open to dual-eligible members with Medicaid and Medicare. Some members have lost HCBS after becoming Medicare eligible (with dual insurance).

A: At this time, duals are not eligible for HARP enrollment.

- 6) How quickly does a H1 change to a H2 or H3 in the E-Paces system?

A: The change in H codes occur within 48 hours.

- 7) Do BH HCBS providers need access to UAS?

A: No, BH HCBS providers do not have access to the UAS at this time.

- 8) Do the HHCM staff that provide the Health Home Care Management services have to meet the same educational/background experience that the NYS EA assessors do, or is their flexibility in allowing the traditional health home CC qualifying staff provide the CC services?

A: The staff qualifications apply to all staff who are performing NYS Eligibility Assessments for BH HCBS. At this time, the State does not mandate these qualifications for all staff providing care coordination for HARP members. The State does, however, want providers to ensure - given the nature of the HARP population - that care coordinators with enough expertise and experience to successfully engage and meet the needs of HARP members are serving them.

- 9) If a member has not signed an information sharing consent form, can the CMA and MMCO still exchange Protected Health Information (PHI) in order to assess the member for and refer the member to BH HCBS services as required by the BH HCBS workflow?

A: CMAs and MMCOs are authorized to exchange PHI in the absence of either a signed consent form or an agreement directly between the MMCO and the CMA governing the exchange. These disclosures and/or redisclosures, in the case of confidential mental health clinical information obtained from Mental Health Facilities, are permitted pursuant to both HIPAA and Section 33.13(d) of the Mental Hygiene Law without the member's consent where the disclosures are for care coordination or payment purposes. While there is no need for a direct agreement between the MMCO and the CMA, CMAs should use due diligence to ensure that CMA staff communicate with the correct MMCO and exchange only the minimum necessary information to achieve the purpose(s) for which the information is being disclosed.