Adult Behavioral Health Home and Community Based Services (BH HCBS)
Questions and Answers
As of January 14, 2016

BH HCBS QUESTIONS:

1. **Q:** Can you receive BH HCBS without being HARP eligible?

   A: As of 1/1/16, BH HCBS are available to individuals in NYC enrolled in HARPs or who are enrolled in HIV SNPs and are HARP eligible, who reach a qualifying score on the NYS Eligibility Assessment (or "brief assessment").

2. **Q:** Will an individual be denied BH HCBS if they do not keep the 3 initial visits authorized under the Level of Service Determination?

   A: An individual will not lose eligibility for BH HCBS solely for missed appointments. The 3 initial visits authorized under the Level of Service Determination are meant to allow the BH HCBS provider to work with the individual to develop an individualized service plan that includes scope, duration, and frequency of the BH HCBS being considered. The BH HCBS provider needs to present this information to the individual's managed care organization utilization management team to obtain prior authorization before further BH HCBS can be offered. If a BH HCBS provider has enough information to request prior authorization despite the individual failing to attend initial appointments, the BH HCBS provider can still request prior authorization and (upon authorization) begin BH HCBS.

3. **Q:** How will the HHCM (Health Home Care Manager) know which BH HCBS providers are in the MCO's (Managed Care Organization) network? Will a list be provided to HHCMs?

   A: The MCOs are required to include BH HCBS providers in their network and have the list of providers available on their website. The State is encouraging MCOs to post these lists promptly. The HHCM must submit a proposed BH HCBS Plan of Care to the MCO for review and approval. As part of this review process, the MCO will share significant prior service use information with the HHCM and will also ensure that the HHCM has accurate information about in-network BH HCBS providers that the individual can choose to receive services from.

4. **Q:** Are the BH HCBS provider visits per each BH HCBS service?

   A: Once a Level of Service Determination is made for each service, there will be a total of 3 visits allowed over 14 days (starting from the 1st visit) for each BH HCBS provider to meet with the individual to collaboratively determine frequency, duration and scope for all BH HCBS the provider will offer. The initial 3 visits are for evaluation only and not for the provision of BH HCBS. If the evaluation is completed sooner than the third visit, the BH HCBS provider may contact the MCO to request

prior authorization for the services as soon as the provider has enough information to make the request; upon receiving authorization, the provider may begin BH HCBS.

5. **Q:** When will BH HCBS be available in New York City?

   A: BH HCBS for adults in New York City began on January 1, 2016.

6. **Q:** At what point does the BH HCBS provider conduct their initial evaluation of the individual for level of services?

   A: After receipt of the MCO approval of the proposed BH HCBS Plan of Care submitted by the HHCM, the Level of Service Determination, and authorization of the initial 3 visits, the HHCM (with assistance as needed from the MCO CM) will facilitate referrals to specific BH HCBS provider(s) chosen by the individual. The BH HCBS provider(s) will meet with the individual to conduct an initial evaluation and collaboratively determine frequency, duration and scope of the service and contact the MCO to request prior authorization for the services.

7. **Q:** Has the State considered how to streamline the process for the client who may need several of the 13 different BH HCBS that may be offered by several BH HCBS providers as many of the providers might only provide some of the BH HCBS?

   A: We anticipate that most individuals will only receive 1-3 BH HCBS. Individuals who demonstrate the need to receive multiple BH HCBS may be able to have their needs met through a more comprehensive service, such as PROS or ACT.

8. **Q:** Is it true that the HHCM offers choice of BH HCBS from a list provided by MCOs and an initial communication with the MCO to obtain BH HCBS provider choices is not needed?

   A: MCOs are required to provide a listing of participating providers. The HHCM must submit the proposed BH HCBS Plan of Care to the MCO for review and approval before an enrollee meets with a BH HCBS provider. The Health Home Care Manager is not required to include a provider chosen by the individual in the proposed POC that is provided for Level of Service Determination. The HHCM may refer, based on the individual's choice, to a specific provider after the Level of Service Determination has been made. Individuals must be offered choice of participating providers and will attest to being offered choice in the signed POC.

COMMUNITY MENTAL HEALTH ASSESSMENT QUESTIONS:

1. **Q:** How does the Community Health Assessment (CMHA) prompt the selection of BH HCBS services? Do scores on the CMHA indicate what services should be offered?

A: The NYS Eligibility Assessment (or "brief assessment") determines eligibility for BH HCBS and if eligible determines which tier of BH HCBS based on qualifying scores. The CMHA (or "full assessment") helps the Health Home Care Manager to identify individual needs. It does not generate a list of specific BH HCBS that an individual is eligible for. The HHCM uses the information generated from the full assessment to help the individual identify specific goals and preferences. The HHCM then educates and advises the individual about specific BH HCBS that would best help the individual attain his/her goals. The proposed BH HCBS Plan of Care will document specific goals, preferences, and desired BH HCBS, and must be presented to the MCO for review and approval. The MCO will offer further input as needed to ensure that the most appropriate BH HCBS are selected.

2. **Q:** Will there be annual reassessment requirements for HARP enrolled individuals?

   A: All HARP enrolled individuals must undergo the NYS Eligibility Assessment annually, regardless of whether they were previously eligible for BH HCBS. If a HARP enrolled individual is newly eligible for BH HCBS based upon an annual reassessment, the HHCM must review BH HCBS options with the individual and complete the CMHA if the individual is interested in receiving BH HCBS. HARP enrolled individuals who were eligible and authorized to receive BH HCBS in the prior year, and who wish to continue receiving BH HCBS, must receive the CMHA and the BH HCBS POC must be updated to reflect changes in goals, preferences, needs and progress. The updated BH HCBS POC must be reviewed and approved by the MCO.

3. **Q:** For individuals that do not make themselves available at the 12 month mark for re-assessment or renewal of a Plan of Care (POC), does the original assessment and POC remain valid and active until the individual can be re-assessed?

   A: The original assessment and Plan of Care (POC) would remain in place until a re-assessment can be completed. However, any authorized service listed in the Plan of Care will have an end date for the authorization. Those authorized services would have to be reauthorized by the MCO before the end of the authorization period to avoid an interruption of care.

4. **Q:** Is the CMHA available in Spanish?

   A: The Community Mental Health Assessment is only available in English in the UAS-NY. The assessment must be conducted in the preferred language of the individual. A bi-lingual assessor or a translator should be used to ensure the assessment is conducted in the preferred language of the individual.

5. **Q:** Does an assessment become invalid after 45 days?

   A: If the process of assessment and POC development is interrupted or delayed (e.g., lost to follow-up, hospitalization, loss of Medicaid eligibility/MCO enrollment,

life changing event, etc.) the HHCM and the MCO must determine on a case by case basis if the individual's change in circumstances is significant and warrants a new assessment to accurately develop goals, preferences, and service needs.

HEALTH HOME/PLAN OF CARE QUESTIONS:

1. **Q:** Does the POC replace the HH Care Plan, as they seem duplicative?

   A: All Health Home plans of care must continue to meet the comprehensive care planning requirements and the Health Information Technology requirements for Health Homes included in the "Health Home Standards and Requirements for Health Homes, Care Management Providers and Managed Care Organizations" (the Standards Document). To ensure those comprehensive care plans include plan of care requirements specifically related to BH HCBS, the State has provided a BH HCBS POC template. The template includes all the elements required by CMS to be in a Health Home's comprehensive POC that includes BH HCBS. 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. HHs are not required to use the template, but if they do not use the BH HCBS POC template, then they must ensure that their POC incorporates the list of elements that the CMS rules and regulations require for the BH HCBS POC. The template and all the elements required by CMS for the BH HCBS Plan of Care can be found on DOH website at: https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/h arp_hiv_snp.htm under the heading "Adult Behavioral Health Home And Community Based Services (BH HCBS) Plan of Care."

2. **Q:** Is the POC expected to have physical health services, behavioral health services, and BH HCBS when completed?

   A: Yes, as required by the Standards Document, all Health Home care plans (those that include BH HCBS services and those that do not) should be comprehensive, i.e., include physical health services, behavioral health services, and community and social supports.

3. **Q:** Can you please clarify the qualifications for supervisors of those administering BH HCBS assessments as expressed in the statement "must have supervision from a licensed clinician with prior experience in a behavioral health clinical or care management supervisory capacity?" Will a license such as R.N. suffice or is restricted to only licensed social workers?

   A: An R.N. with the prior experience in a behavioral health clinical or care management supervisory capacity would suffice. The assessor qualifications can be found at:

http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/harp_hiv_snp.htm.

4. **Q:** Can MCOs mandate that Health Homes send the entire POC as MCOs have incorporated medical reviews into our process and are expecting that this POC is a truly integrated POC?

   A: MCOs at any time can request the full POC for any of their Health Home enrolled individuals. It is currently only mandated that the HH share the POC with the MCO for those individuals receiving BH HCBS.

5. **Q:** Is there a client ratio per HH Care Manager for individuals enrolled in HARPs?

   A: There is no client ratio per care manager for individuals in HARPs and receiving BH HCBS at this time. Health Home Plus regulations include HHCM caseload requirements for individuals receiving Assisted Outpatient Treatment (AOT), regardless of whether they are BH HCBS eligible.

6. **Q:** Should there be a dedicated care manager designated to work only with individuals enrolled in HARPs and receiving BH HCBS?

   A: It is up to the HH and their care management agencies to decide if a dedicated care manager for this population would work best for their recipients and the care management agency.

7. **Q:** Will DOH provide translation line for Health Homes or provide funds for Care Management Agency in support of such a line?

   A: HH development funds can be used for translation line services. It falls in the category of member engagement and Health Home promotion. Health Homes and care managers should note that the Health Home core requirements, as included in the Standards Document, require Health Home providers to communicate and share information with individuals and their families and other caregivers with appropriate considerations for language, literacy and cultural preferences.

8. **Q:** Please clarify the process for completing the HH Assessment and Community Mental Health Assessment (CMHA) when a client enrolls in a HH and HARP simultaneously.

   A: Each Care Management Agency (CMA) must determine the best process to complete both the HH Assessment and the CMHA for an individual enrolled in a HARP. CMAs should take into consideration the need to prioritize completing the NYS Eligibility Assessment (or "brief assessment") on HARP-enrolled individuals who are already enrolled in a Health Home. The Standards Document has the following guidelines for HARP enrollees:

"As a best practice Health Home care managers shall complete NYS Eligibility Assessment (or "brief interRAI/brief 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 NYS Eligibility Assessment and NYS CMHA (or "brief and full assessments"), 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."

9. **Q**: If an MCO is delayed in approving or denying the POC, what process should the HH follow?

   A: As per Appendix F of the Model Medicaid Managed Care Contract, if the MCO is unable to complete the review within required timeframes, it is considered an adverse determination, and the MCO is required to issue a notice of action with appeal rights.

10. **Q**: Will BH HCBS providers receive a copy of the final POC? If so, when and how?

    A: BH HCBS providers should not automatically receive a copy of the individual's POC as it may contain Protected Health Information (PHI) that may not be releasable to the provider. The HHCM should determine when and how much information from the POC should be shared with individual providers following State and federal guidelines regarding confidentiality of PHI. The HHCM can share the POC with BH HCBS providers that are listed on the members consent form. Regardless of whether the POC is shared, as required by the Standards Document, the HHCM should ensure that BH HCBS providers, who are part of the interdisciplinary team of providers included in the comprehensive plan of care are informed of the overall individual's care needs.

MANAGED CARE QUESTIONS:

1. **Q:** Within step B - if the MCO is in agreement with the BH HCBS plan and scope but has questions on other aspects of the plan of care, can MCOs authorize just the BH HCBS service to meet timeframes (this is specifically within step B)?

   A: The MCO is always required to make determinations on service authorization requests as fast as the individual's condition requires. The MCO may approve the BH HCBS level of care in the proposed POC and separately continue to work collaboratively with the HHCM to complete the integrated POC. However, the level of service review for the POC is not generally anticipated to be an urgent request, and, if practicable, the MCO should ask for more information or share data with the

HHCM to update the POC within the review times, including using the extension process if needed, to complete development of an integrated plan of care.

2. **Q:** The MCO contract generally dictates the content of letters authorizing services. Are each of the three letters/approvals outlined in the presentation considered pre-service utilization review letters?

   A: The review of the proposed POC is a level of service review. A potential denial or partial denial of the proposed POC (if discrepancies cannot be corrected during the review period) may be for lack of medical necessity (e.g., the MCO has information that the level of service proposed is clinically inappropriate for the individual; the service is not likely to facilitate recovery or prevent destabilization; or the service does not meet the individual's goals, etc.) or may be administrative (e.g., because the HHCM failed to demonstrate they offered choice of provider, or named providers are non-participating, etc.). The initial review of the BH HCBS provider service authorization requests are pre-service determinations, and a reason for denial may be either for lack of medical necessity or administrative (e.g. non-participating provider, or benefit limit reached, etc.).

3. **Q:** Since DOH uses a model Utilization Review notice, will they be updating this model for use in these cases?

   A: The model Initial Adverse Determination (IAD) does not require updating for this purpose. The "other decision" reason in the model template is meant to allow the MCO to add an alternate reason that is not included on the model's list. The MCOs may also adjust the specific reason for denial free text placeholder, as needed. MCOs may submit a revised template to DOH for approval at any time.

4. **Q:** What are the two levels of service that the client could get pre-authorized for?

   A: BH HCBS are grouped into 2 Tiers based upon the NYS Eligibility Assessment threshold scores. Tier 1 BH HCBS are offered to individuals with lower scores ("moderate" need) and include peer support services as well as educational and employment supports. These services were designated Tier 1 to ensure that individuals in HARPs who are further along in their recovery (and may have fewer functional needs) will have access to services that will continue to support their recovery. Other BH HCBS target individuals with more extensive functional needs that will meet the "extensive" or Tier 2 eligibility criteria. Individuals eligible for Tier 2 services may receive ALL BH HCBS, including Tier 1 BH HCBS.

5. **Q:** When will the MCO receive a determination of BH HCBS tier following the assessments?

   A: The BH HCBS screen summary document will include the algorithm noting eligibility Tier. The BH HCBS tier should be included in the POC and the MCO will review this information as part of review of the proposed BH HCBS POC. In addition,

the updated H codes reflecting an individual's BH HCBS eligibility and tier will be added by the State to the enrollee's eligibility file after the completion of the assessments in UAS, based on a weekly data feed. The MCO will see this information on the next enrollee roster generated subsequent to when the data feed is processed.

6. **Q:** By Level of Care determination, like with ACT (Assertive Community Treatment), is this referencing the Letter of Support that we have created for ACT?

   A: Approvals for the level of care in the proposed POC is similar to the approval of the ACT referral, however, for ACT, the request is for a referral and a determination to deny the request is generally administrative.

7. **Q:** Do authorization letters need to be sent to HH and BH HCBS providers from the MCO? If so, does it also have to go to the individual?

   A: All notification requirements for service authorization determinations as in Appendix F of the Medicaid Managed Care Model Contract apply.

8. **Q:** Are there language requirements for the authorization letters?

   A: All notice language requirements as provided by statute, regulation and the Medicaid Managed Care Model Contract apply.

9. **Q:** While the MCO does not need to approve entire POC, the MCO still may need to approve some services requiring prior authorization. Does that mean approvals could come separately?

   A: Approval of the POC is a level of service approval and approval of an authorization for 3 visits to evaluate the individual; an approval of the POC is not an authorization for any of the services indicated. All services listed in the POC are made available to the individual only as actually ordered by the service provider and authorized by the MCO (in accordance with the MCO's service authorization requirements and procedures).

10. **Q:** Some of the MCOs are contracting with specific behavioral health agencies to perform Care Management activity for individuals enrolled in HARPs. Is the MCO prohibited to have the contracted agency perform this activity?

    A: At this time, only HHCMs may perform the NYS Eligibility Assessments and the NYS Community Mental Health Assessment**.** MCOs have been instructed to work collaboratively with HHCMs to ensure all individuals receive adequate and appropriate care management.

11. **Q:** MCOs are contractually required to approve the POC. Does that mean MCOs do NOT have to approve the HH POC, but only the request for BH HCBS?

A: At this time, the MCO is responsible for making a level of service determination on the proposed plan of care only when the POC includes a recommendation for BH HCBS. However, the MCO is also responsible for ensuring that a person-centered POC is developed for all of its enrollees receiving HH services.

12. **Q:** MCOs will have to apply their Medical Necessity (MN) criteria to all physical and behavioral services included in the Plan of Care because of restrictions imposed by law in later denying payments for services that did not meet the MN criteria when they previously approved such services. Normally these services may not require Prior Authorization. Does that mean MCOs would require providers to comply with criteria without Prior Authorization?

    A: NYS Insurance Law §3238 and 10 NYCRR §98-1.13(n) generally prohibits the reversal of a prior authorization unless certain circumstances exist. Approval of the POC is not an authorization for any of the services indicated. All services listed in the POC are made available to the individual only as actually ordered by the service provider and authorized by the MCO (in accordance with the MCO's service authorization requirements and procedures). Further, the MCO may specifically structure their POC approvals as applicable only to the BH HBCS plan of care and approval for three evaluation visits with the BH HCBS providers. The notice of approval may include a statement that services in the POC may be subject to the MCO's service authorization requirements. The approval of an authorization for evaluation visits does not bar the MCO from determining that additional services, as may be requested by the provider after such evaluation is concluded, are not medically necessary.

13. **Q:** There will be many plans of care that the MCOs must review. What is the expectation for turnaround regarding MCO review of the plan of care?

    A: Level of care decisions are to be made within standard review timeframes: 3 business days of all information, and no more than 14 days from receipt, with possible extension of up to 14 days if requested by the individual or provider, or if the MCO needs more information and the delay is in the individual's best interest.

14. **Q:** Are MCOs supposed to sign the plan of care or will a letter indicating approval meet this need?

    A: A letter indicating approval is acceptable.

15. **Q**: Will the Level of Service Determination document indicate MCO agreement with the results of the UAS-NY (i.e., that the individual is appropriate for Tier 1 or Tier 2 BH HCBS?) or does the determination serve a different purpose? What information will it include exactly?

A: Yes. The assessment results provide information that supports the tier and BH HCBS recommendation. An MCO's approval of the POC indicates that the MCO agrees the level of BH HCBS indicated is appropriate for the individual and will facilitate recovery, assist the individual to achieve their goals; or prevent destabilization. An authorization for 3 evaluation visits for each recommended BH HCBS provider must be included in the MCO approval of the POC, or may be issued in separate notice at the same time as the approval of the POC.

16. **Q**: To whom will MCOs be issuing the Level of Service Determination (e.g., the HH, the CMA, the BH HCBS providers)?

    A: The MCO will be providing the Level of Service Determination to the HH, HHCM and the BH HCBS provider.

MAPP AND BILLING QUESTIONS:

1. **Q:** Is there a future goal of having data from the UAS (Community Mental Health Assessment results) transmitted to MAPP as a central data collection point?

   A: Phase 1 of MAPP will include the type of assessment done, the date the assessment was completed, and other information included in the data feed to Managed Care Plans and Health Homes to facilitate the process for billing CMHAs. Additional assessment information may become available in MAPP based on provider feedback in future phases.

2. **Q:** Will HARP billing rates be effective as of January 1 or are they being pushed back to September 2016?

   A: The High, Medium, and Low Health Home rates will be effective with September 2016 service dates.

3. Q: Please provide information on the data feed that will be sent to MCOs on completed assessments. When and how will it be sent, and who is the recipient?

   A: The data feed will be sent through the secure file transfer application in HCS. The data feeds will be sent on a bi-weekly basis. They will be sent to the HARP and Health Home designated contact.

4. **Q:** When will the assessment rates be available?

   A: The rates for the NYS Eligibility Assessment and NYS CMHA, as well as the POC rate (for individuals who are not enrolled in HH) went live as of 12/18/15. New billing guidance has been issued and posted to the Health Home website.

5. **Q:** Will MCO facilitate payment for BH HCBS assessments?

A: Yes. The HARPs will use the bi-weekly data feed to bill Medicaid for the completed BH HCBS assessments. The payment will be passed to the Health Home, who will pay the assessing entity for Health Home enrolled members. See billing guidance that has been posted to the Health Home website. The State is working to finalize billing procedures CMHAs and POCs for members who are not enrolled in a Health Home.

6. **Q:** Regarding the reimbursement process for BH HCBS providers for assessing the frequency, scope, and duration of services, please clarify whether providers will be compensated for the service per unit or receive a payment for up to three visits?

   A: The BH HCBS provider will bill for the BH HCBS rate codes and follow the process as outlined in the billing manual available at: http://www.omh.ny.gov/omhweb/bho/billing-services.html

PROCESS/ TIMELINE QUESTIONS:

1. **Q:** When does the individual get notified of the approved POC?

   A: The individual receives notification of the MCO's approval from the MCO at the time of the determination as per Appendix F of the Medicaid Managed Care Model Contract.

2. **Q:** Could the time between initial contact with the individual to the time the POC is approved, which involves a lot of "back and forth" between HH, MCO and BH HCBS providers, cause the individual to disengage?

   A: The HARP model and BH HCBS are designed for individuals with high rates of disengagement from care. The assessment process involves numerous steps so it is possible an individual may be lost to care. However, the HHCM should aim to use the assessments to engage and empower the individual in a process of self-direction and care planning that is driven by the individual's goals, preferences, and needs.

3. **Q:** Can the individual request amount duration and scope of services without provider involvement?

   A: Individuals requesting services from the MCO may be directed to have the provider submit a service authorization request. If the individual requests services from the provider, and the provider refuses, the individual may file a complaint with the MCO, at which time the MCO must issue a determination either supporting the provider's denial (with appeal/fair hearing rights notification) or approving the service, and assist the individual in obtaining the service.

4. **Q:** How will the HHCM incorporate the PH and BH needs within the initial plan of care without a conversation with the MCO?

   A: It is the role of the HHCM to ensure they obtain all the individual's PH and BH care information to develop an integrated POC and provide person-centered comprehensive care management that meets the requirements and standards provided in the Standards Document. Therefore, HHCM should be contacting the MCO at any point in the care planning process to ensure that they have adequate and timely information to develop the POC. The MCO is required to share information with the HH regarding the individual's service history. The Standards Document provides additional information regarding requirements for communicating and sharing information between Plans and Health Homes.

5. **Q:** What if the individual doesn't agree with the requested services, amount, duration and scope?

   A: The HHCM should work with the individual and BH HCBS provider to develop a POC that all parties support. HHCMs should play an important role in resolving potential disagreements and/or helping the individual consider other BH HCBS options. The individual may ask the provider for more services, file a complaint with the MCO and request additional services, or request a State fair hearing to review the benefit provided.

6. **Q:** What if an individual is not eligible for BH HCBS or wants a service not determined to be needed by the plan of care, can they appeal and if so to whom?

   A: If the individual is determined not to be eligible for any BH HCBS, the individual will receive notice with right to fair hearing at that time. If the individual requests services from the provider, and the provider refuses, the individual may file a complaint with the MCO, at which time the MCO must issue a determination either supporting the provider's denial (with appeal/fair hearing rights notification) or approving the service, and assist the individual in obtaining the service.

7. **Q:** We understand that the BH HCBS tier will be indicated with the initial plan of care, but when will the enrollment file indicate the tier and be provided to the MCO?

   A: On a weekly basis, the updated H codes reflecting an individual's BH HCBS eligibility and tier will be added by the State to the enrollee's eligibility file after the completion of the assessments in UAS. The MCO will see this information on the next enrollee roster generated subsequent to the update to the individual's H code.

8. **Q:** Will separate guidance be developed offering clarification regarding MCO approval process, from Level of Service letter to pre-authorization, authorization and final approval letter?

   A: Yes. This guidance will be developed.

9. **Q:** Could DOH develop a time frame visual with all of these time frames?

   A: Timeframes have been added to the POC workflow.

10. **Q:** Who will be transmitting the POC and through what mechanism? Is that TBD between the HH and MCOs?

    A: Transmission of the POC will be determined between the HHs and the MCOs. There have been some discussions about using the secure file transfer application in the HCS.

11. **Q:** If the POC is based on the BH HCBS assessment and MAPP will be the mechanism by which the MCO can make sure the POC supports the needs identified on the assessment, how will the MCOs be able to see the assessment if MAPP is delayed until March?

    A: The assessments themselves will not be housed in MAPP. Only information on the date the assessment was completed and the type of assessment that was completed will be available in MAPP for HH members. Completed assessments can be viewed in the UAS system**.**

12. **Q:** What happens to the clock, if the MCO rejects the proposed POC? Does the clock start again when the revised POC is sent back to the MCO?

    A: The review time is not tolled while the MCO is seeking more information or clarification about the proposed POC**.** The review period ends with the MCO determination to approve or deny the POC. If a revised POC is submitted after the determination is issued, it may be reviewed by the MCO under appeal times as indicated in Appendix F of the Medicaid Managed Care Model Contract.

13. **Q:** The current process seems to reflect approval of prior authorizations with (frequency, scope, and duration) prior to review of the finalized POC. Shouldn't the approval of the POC be done before or simultaneously? What if the MCO does not approve the POC?

    A: In the revised process, the MCO approves the level of care in the proposed POC, and thereafter responds only to the provider service authorization requests.

14. **Q:** Why can't the HHCM submit the final approval to the MCO and then move forward with a final plan of care?

    A: The process for approving the POC requires the MCO approves the level of care in the proposed POC, and thereafter responds only to the provider services authorization requests. The HHCM receives the authorizations, copies the MCO, and updates and implements the POC.

15. **Q:** The initial BH HCBS POC is approved by the MCO in step B before the BH HCBS assessment. What if the assessment differs when done face to face?

    A: The MCO receives the proposed POC after the HHCM assessments are completed. Services indicated in the POC are available to the individual only upon actual order of the provider. If the provider, upon evaluation, determines that the BH HCBS is not appropriate, the provider does not request authorization for the service, and the HHCM updates the POC and shares this information with the MCO.

16. **Q:** Is the HHCM required to include a more comprehensive plan of care of the individual's medical conditions, in addition to noting how someone's medical condition would affect their ability to engage in BH HCBS services?

    A: The Health Home core requirements and the Standards Document require a comprehensive, integrated (physical, behavioral and social/community supports), person-centered plan of care that involves an interdisciplinary team of providers to be developed for ***all*** Health Home members, including HARP members.

17. **Q:** At what point does the individual sign a copy of the POC?

    A: The individual should sign the POC before it is submitted to the MCO.

18. **Q:** If the HH does not complete the POC, what process should the MCO follow?

    A: MCOs are required to ensure POCs are developed. The MCO may consult and collaborate with HH to determine the cause of the delay and resolution. Note, the MCO must have a process to monitor participating HH performance.

19. **Q:** Please clarify that the BH HCBS providers are responsible for submitting request for authorization (Step C) and the HHCMs are responsible for submitting the final POC to the MCO (Step D)?

    A: Yes, BH HCBS providers are responsible for submitting requests for authorization and HHCMs are responsible for submitting the updated POC to the MCO.

20. **Q**: If the individual or BH HCBS provider wishes to revise the frequency, scope, or duration of BH HCBS before the prior authorization has expired or before the annual POC revision, must a new assessment and/or POC be completed?

    A: The POC should be updated when there are changes to any of the services an individual receives. The BH HCBS provider must request authorization from the MCO for an increase in the frequency, scope, or duration of the services. A new assessment is conducted if there has been a significant change.

21. **Q**: If the HHCM does not include specific BH HCBS providers, as outlined in B.1. would the MCO reach out to either the HHCM or the BH HCBS provider in this scenario?

    A: The MCO could reach out to the HHCM to assist in choosing BH HCBS providers so long as the individual is offered choice among providers.

22. **Q**: What tools or guidance can the BH HCBS provider reference to determine the frequency, scope, and duration of services?

    A: BH HCBS providers have been designated to provide BH HCBS based on their application that described their experience providing similar services. In addition, the Managed Care Technical Assistance Center (MCTAC) has provided several trainings describing in detail the components of each BH HCBS. Materials from these trainings can be found at www.mctac.org.

23. **Q**: Whenever an individual requests a change in BH HCBS (or other) provider, does the POC have to be updated?

    A: Yes, the POC would be updated when there are changes to the services an individual receives.