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of Health

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To: All NYS Health Homes, Health and Recovery Plans (HARP), HIV Special Needs Plans (HIV SNP) and Behavioral Health Home and Community Based Service (BH HCBS) Providers

Subject: Revised Adult BH HCBS Workflow Guidance for HARP and HIV SNP Members Enrolled in Health Home – Effective 10/1/2017

Purpose

In previous guidance issued by the State, the process for a HARP member to access Adult Behavioral Health Home and Community Based Services (BH HCBS) included a two-step assessment: the NYS Eligibility Assessment to determine the member's eligibility for BH HCBS, followed by the NYS Community Mental Health Assessment (or "Full" Assessment) for the development of a comprehensive plan of care inclusive of BH HCBS. **Effective March 7, 2017, the State announced that the Full NYS Community Mental Health Assessment is no longer required for BH HCBS purposes**, in response to member and stakeholder feedback seeking to reduce the assessment burden on the member, and to align with Health Home assessment policy and procedure.

This 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. Throughout the entire workflow described herein, the Health Home Care Manager (HHCM), the HARP and HIV SNP Plans (hereafter "MCO"), and BH HCBS provider(s) will all work to ensure members are given opportunity to explore BH HCBS, and work together to finalize a person-centered Plan of Care (POC) inclusive of BH HCBS for any members who are eligible and interested in 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.

The State remains committed to working with Health Homes, MCOs, BH HCBS providers and other stakeholders to explore ways to further streamline and improve the assessment and authorization process for BH HCBS.

BH HCBS Workflow Guidance (also see [BH HCBS Workflow Visual](#))

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.

- **NYS Eligibility Assessment**

HHCMs will use the NYS Eligibility Assessment to determine if HARP-enrolled or HARP-eligible HIV SNP enrollees are eligible for Adult BH HCBS. The NYS Eligibility Assessment will determine Tier 1 Eligibility (employment, education, and peer support services only), Tier 2 Eligibility (full array of BH HCBS), or No BH HCBS Eligibility.

The 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. Prior to conducting the assessment, the HHCM must verify current HARP or HIV SNP enrollment through EPACES/EMEDNY. Lead Health Homes must also ensure all CMAs are provided real-time access to HARP enrollment information for their members.

- HARP-enrolled individuals will be identified with one of the following restriction exception (RE) codes:
 - H1 - HARP Enrolled without HCBS
 - H4 - HIV SNP Enrolled, HARP Eligible without HCBS
- 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 with an H9 code are HARP eligible but pending enrollment in a HARP. For information on how to assist someone to enroll in a HARP, see [here](#).

The NYS Eligibility Assessment can only be performed by qualified HHCMs as defined in the [NYS BH HCBS Assessor requirements](#).

The NYS Eligibility Assessment must be completed face-to-face with the member. For more information regarding BH HCBS requirements for independent assessment, see [Section 1915\(i\)\(1\)\(F\) of the Social Security Act](#).

Best practice for completing the NYS Eligibility assessment is thirty (30) days of Health Home enrollment. The HHCM has the option to initiate the NYS Eligibility Assessment as soon as they receive a new member assignment (for example, using this tool as part of an intake/outreach process). If the member was enrolled in Health Home prior to their enrollment in the HARP or HIV SNP, the HHCM will have 30 days from member's HARP or HIV SNP enrollment date to complete the NYS Eligibility Assessment.

There are circumstances that will result in the individual *not* pursuing BH HCBS after completing the NYS Eligibility Assessment. In these scenarios, the HHCM would not move forward with the remaining workflow described in this document, but will instead continue to work with the individual in their role as a HHCM on the completion of required Health Home assessments, plans of care and referrals to other service providers. Scenarios include:

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 (see NYS' ["HCBS Final Rule Statewide Transition Plan"](#) for more information). **At the point when the individual later chooses to move out of this ineligible setting and into a BH HCBS eligible setting**, the care manager should ensure an NYS Eligibility Assessment has been completed and begin the process to connect the individual to BH HCBS (if the individual chooses). Ideally this process will start early enough to allow the individual to begin to receive BH HCBS immediately upon entering the eligible setting.

If the individual is not pursuing BH HCBS for any of the reasons described above, HHCMs will document this within the UAS assessment platform, once that capacity is added, as well as in the member's Plan of Care.

If the individual declines the NYS Eligibility Assessment, this information should be documented in the member's Plan of Care.

- **Person-Centered Discussion about the Individual's Recovery Goal(s)**
The assessment shall prompt a person-centered discussion with the individual about their recovery goal(s), and how BH HCBS, State Plan, and/or Medical services may help achieve their goals. In some situations, the individual may already be receiving a State Plan service - such as Personalized Recovery Oriented Services (PROS), Assertive Community Treatment (ACT) or clinic services - that meets their needs and cannot be combined with some BH HCBS, or may not be interested in receiving

BH HCBS. The HHCM should help the individual make an informed choice about which available services best addresses their health needs and goals.

For example, an individual who has an employment goal and identifies barriers in the areas of personal hygiene, social skills, and wellness self-management may prefer a classroom or group setting where he or she can address these barriers with peers. A discussion with the individual about a PROS program, for example, which is primarily a site-based program offering a comprehensive package of services, may better address the individual's multiple barriers than a BH HCBS employment service alone.

There are several other program types that a care manager could offer an individual through OMH or OASAS providers to address treatment and/or rehabilitation needs. 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.

A list of allowable State Plan and BH HCBS service combinations can be found [here](#).

- **Level of Service Determination for BH HCBS**

After the HHCM completes the NYS Eligibility Assessment and determines that the individual is eligible for and interested in a referral to BH HCBS, the **HHCM submits a BH HCBS Level of Service Determination request to the individual's MCO.**

This request may be made in a written or verbal format, as agreed to by the MCO and the HHCM. At minimum, the request shall include the following information:

1. BH HCBS Eligibility Report Summary (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.

The MCO will review the request and issue a Level of Service Determination within 3 business days of receipt of all information (as listed above), but no more than 14 days of the request. The MCO may extend this time by up to 14 days, if the MCO needs more information and the extension is in the individual's best interest. If the MCO approves the Level of Service request, the Level of Service Determination will include confirmation that the level of BH HCBS proposed for the individual is appropriate. The MCO may issue one Level of Service Determination for all BH HCBS proposed when more than one BH HCBS is requested.

Note: The Level of Service Determination should not be mistaken for an authorization for services but rather the MCO's agreement with the level of BH HCBS proposed by the HHCM. 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).

The MCO will work with the HHCM toward resolution of any issues impeding approval of the Level of Service request. If the MCO ultimately determines to deny the Level of Service request, the MCO will issue an initial adverse determination with applicable appeal and fair hearing rights.

At any time throughout the process, additional needs may be identified by the member, care manager and/or another provider after an initial Level of Service Determination has already been issued. If a BH HCBS needs to be added to the individual's POC, the care manager will need to submit an updated Level of Service Determination request. All previously approved BH HCBS should be included so the MCO can review the full package of BH HCBS. The MCO will issue a new Level of Service Determination, which the care manager will use to make BH HCBS referrals.

Individuals must be given a choice of BH HCBS providers from the MCO's network and must be documented in the member's POC that such choice was given to the individual. The care manager shall ensure that when assisting the individual in choosing BH HCBS provider(s), that this is done using a conflict-free approach, per the requirements outlined in "[Health Home Standards and Requirements for Health Homes, Care Management Providers and Managed Care Organizations](#)".

- **Referrals to BH HCBS**

The HHCM should ensure referrals are made in a timely fashion and should work to keep the member engaged, ensuring linkage to services. This may include sending reminders for appointments, contacting the member and/or providers throughout the referral/intake process, and offering transportation, as needed. If Non-Medical Transportation is needed, the HHCM and MCO should follow the process as outlined in "[Guidance for Behavioral Health Home and Community Based Non-Medical Transportation Services for Adults in HARPs and HARP Eligible in SNPs.](#)"

Upon receipt of the MCO's Level of Service Determination, **the HHCM makes a referral for BH HCBS to the individual's choice of provider(s)**. 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 (see above), to the BH HCBS provider(s).

The BH HCBS provider may request additional documentation; however, the provider should be aware that the individual's complete Plan of Care will not be available at point of referral, and shall not unnecessarily delay access to services pending receipt of documentation.

- **Intake/Evaluation by BH HCBS Providers**

Upon receiving the referral from the HHCM, each BH HCBS provider shall notify and provide the MCO with the date of their initial scheduled intake/evaluation appointment with the individual. If this initial date changes, the BH HCBS provider must notify the MCO. 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 of BH

HCBS. 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**

After completing the intake/evaluation (or the first 3 visits, whichever comes first), in order to request MCO authorization to provide ongoing BH HCBS, the BH HCBS provider must submit the [Adult Behavioral Health Home and Community Based Services \(BH HCBS\): Prior and/or Continuing Authorization Request Form](#) with recommended frequency, scope and duration to the MCO. The MCO will review the documentation provided and issue a determination within authorization request time frames described in the [Medicaid Managed Care Model Contract](#). **The MCO must inform the HHCM, BH HCBS provider, and the individual of the determination.** 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. Once the BH HCBS provider has received authorization for scope, duration and frequency of BH HCBS, the BH HCBS provider must notify the HHCM to add these details to the individual's Plan of Care.

- **HHCM Completes and Submits the BH HCBS Plan of Care to the MCO**

The HHCM “holds” the overall Plan of care, which is driven by the individual's life and recovery goal(s). BH HCBS, behavioral health, medical, community and natural supports all help to support that individual in reaching their goal(s), and are therefore included on the POC. 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. The HHCM shall work with family, supportive friends, providers, and the MCO, as applicable, to assist in the development of the POC. The POC, inclusive of BH HCBS, is the framework for communicating the individual's service needs between the HHCM, the BH HCBS provider and the MCO.

Individuals already enrolled in a Health Home will have a comprehensive, integrated and person-centered Plan of Care to build on (per requirements of the DOH Health Home Standards). Due to federal requirements associated with BH HCBS, there are additional key elements required within the Plan of Care for those receiving BH HCBS. The federal requirements for BH HCBS can be found here: [BH HCBS Plan of Care Federal Rules and Regulations Checklist](#). Many of these additional elements are already collected by the HHCM as part of the standard Health Home comprehensive assessment process.

Health Homes have the option to either incorporate the BH HCBS federal requirements into their existing Health Home POCs, or use the State-issued [BH HCBS Plan of Care Template](#).

We encourage that an individual be given the opportunity to sign the POC whenever it is revised for any reason. However, **at a minimum, the individual must sign the POC at least once prior to submitting the completed POC to the MCO.**

The HHCM shall ensure that all BH HCBS providers listed in the Plan of Care sign the POC. All other providers listed in the Plan of Care should sign it as well, as

active participants to the individual's comprehensive, integrated POC. However, inability to obtain these provider signatures will not impact the MCO Level of Service Determination, authorization, 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. The MCO and/or Lead Health Home may be able to assist the care manager in engaging providers that are not actively participating in the individual's coordinated care plan.

After all required elements are added to the Plan of Care, the HHCM will submit the POC to the MCO. The MCO will monitor for timely completion of the BH HCBS NYS Eligibility Assessment and POC, and may work with Health Homes to improve any quality issues, such as unnecessarily delayed assessments or incomplete POCs. The MCO will work with the HHCM as needed to ensure POCs are comprehensive, integrated, person-centered, and that the BH HCBS listed in the POC are appropriate for helping the member attain their recovery goals. The State will issue further guidance on resolving scenarios where there are protracted delays in the completion of Plans of Care and/or other documentation required. If the Plan of Care is updated to reflect changes in BH HCBS, the revised Plan of Care should be shared with the MCO.

At this time, there is no requirement for MCOs to approve POCs prepared by HHCMs that are not inclusive of BH HCBS. However, MCOs may request the POC for any of their members as deemed clinically necessary.

- **Ongoing Monitoring of the POC**

HHCMs will work to engage all providers included in the individual's POC to support a truly integrated, coordinated plan. The POC may be updated as new needs are discovered or as the individual's goal(s) change over time.

The NYS Eligibility Assessment is valid for the period of one year from the date of completion. Therefore, annual re-assessment for BH HCBS eligibility is required for all HARP members and HARP-eligible HIV SNP members to determine functional impairment and continued need for BH HCBS, including for those previously deemed not eligible for BH HCBS at their last assessment.

The HHCM will use the NYS Eligibility Assessment to reassess the individual at least annually, and/or after a significant change in the individual's condition *warrants a change be made to the individual's Plan of Care*. The POC shall be updated to reflect changes in the individual's needs, goals, BH HCBS eligibility, and/or services needed.

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.