10/1/2020
Created by HH/MCO HCBS Subcommittee

Adult Behavioral Health Home and Community Based Services (BH HCBS) Workflow History and FAQ

Purpose of this Document: The purpose of this document is to act as the record of the policy developments and modifications to HARP Adult HCBS workflows. The FAQ format outlines the best practices agreed upon by stakeholders that make up the HCBS subcommittee.

General BH HCBS & HARP Resources:

- OMH Adult BH HCBS Resources and Guidance
- E-Paces
- HCBS Revised Guidance 2017
- Adult HCBS Visual Workflow
- HARP Mainstream Billing Manual
- RE Codes
- MCTAC
- Waiver of Qualifications for HH+ SMI and NYS EA Assessors for Adult BH HCBS
- DOH Adult HCBS FAQ
- Training Webinar: Completing the HCBS POC and Person-Centered Care Planning

For more information on BH HCBS contact:

- OMH HARP inbox 'Adult-BH-HCBS' <Adult-BH-HCBS@omh.ny.gov>
- Contact your Regional Planning Consortium

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GLOSSARY

ACT: Assertive Community Treatment
CMA: Care Management Agency
CMHA: Community Mental Health Assessment
CMS: Centers for Medicare and Medicaid Services
EA: Eligibility Assessment
HARP: Health and Recovery Plan
HCBS: Home and Community-Based Services
HHCM: Health Home Care Management
HIV-SNP: Human Immunodeficiency Virus - Special Needs Plan
ISP: Individualized Service Plan
LOSD: Level of Service Determination
LOSR: Level of Service Request
MAPP: Medicaid Analytics Performance Portal
MCO: Managed Care Organization
POC: Plan of Care
PROS: Personalized Recovery Oriented Services
RCA: Recovery Coordination Agency
RE Code: Recipient Restriction Exception Code
RPC: Regional Planning Consortium
SDE: State Designated Entity
UAS: Uniform Assessment System

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BH HCBS Workflow Development- Guidance Timeline

Click Bolded Headings to view source Guidance

2015: HARP begins in NYC. 2016: HARP expands to ROS.

2017 Q2

- **EMedNY CMA Assessment Direct Billing**
  - CMAs only have to complete the Brief Eligibility Assessment and no longer complete the CMHA; CMAs bill Medicaid directly instead of through eMedNY

2017 Q4

- **HCBS Workflow update**
  - The final version of the HARP HCBS workflow released, including a visual representation
- **Standardized state POC template released**
  - A universally accepted—though not required—Plan of Care template was developed

2018 Q1

- **Increase in HCBS Billing Rates**
  - HARP HCBS billing rates were increased in part due to provider/stakeholder feedback
- **Continuity of Care for HCBS without Reassessment**
  - Plans no longer able to disrupt service provision for failure to complete annual reassessment

2018 Q2

- **State Infrastructure Funds to increase HCBS Utilization**
  - MCOs were given additional funding to contract with organizations in order to develop innovative techniques meant to increase HARP HCBS utilization
- **RCAs established**
  - In response to low assessment rates, a new entity was developed solely to complete assessment and connect to HCBS providers for members not enrolled in Health Home

2019 Q3

- **Assessor Qualifications Updated**
  - Staff qualifications to administer the UAS brief eligibility assessment were modified to account for state-wide shortages of credentialed staff

2019 Q4

- **HCBS Redesignation Expansion**
  - NYS allowed for currently designated providers to expand both types of service and areas of service provision

2020 Q2

- **Proposed transition to new waiver**
  - See MCTAC for further information

FAQ and Best Practices: Adult BH HCBS Workflow

HARP ENROLLMENT AND ELIGIBILITY

Q.) How do I know if member is enrolled in HARP?
A.) Check ePaces (https://www.emedny.org/epaces/). Care Management agencies should check ePaces for all enrolled clients to determine who is enrolled in HARP (HARP enrolled clients have an H1 code).

Best Practice: Care Management agencies should discuss the benefits of HCBS with clients during care planning meetings and during case conferencing with providers. For a list of HARP RE Codes see link in General Resources.

Q.) Can the MCO enroll H9 members into HARP?
A.) No, the MCO is prohibited from direct enrolling members into HARP.

Q.) Can a Health Home Care Manager enroll a member into HARP?
A.) Only members with an H9 restriction exception (RE) code can enroll into HARP. A Health Home Care Manager can help members understand the benefits of HARP and assist H9 members enroll in HARP by calling state enrollment broker MAXIMUS (855-789-4277).

Q.) How does a member become H9 HARP-eligible?
A.) The state enrollment algorithm flags Mainstream Medicaid members as H9 based on service utilization and diagnosis. Neither providers nor plans can designate a member as H9.

Q.) Does the RE code change when member transitions from HIV-SNP (codes H4, H5, H6) to HARP plan?
A.) No, the codes do not update when a member changes plans. Use the following to determine translation. H1= H4; H2=H5; H3=H6

Q.) Are H9 members eligible for HCBS?
A.) If the individual's e-PACES report has an H9 code, then the person is HARP eligible but has not yet enrolled in a HARP. Contact state enrollment broker MAXIMUS to enroll H9 members in HARP. Once enrolled, their code will change to H1 and the client will be eligible for HCBS.

ASSESSMENT

Q.) How can I tell how many times a member has been assessed?
A.) Epaces can show whether a member has had an assessment in the past but to determine how many times a member has been assessed, or when the last assessment was conducted, you would need to view the member's case file in UAS. Member is allowed 3 assessments per calendar year.

Q.) If member is accessing HCBS and the eligibility assessment expires, should a new assessment be conducted?
A.) The eligibility assessment should be completed annually, and CMAs and RCAs should track when assessments are due. Members will not lose access to HCBS while awaiting reassessment.

Q.) Where is the eligibility assessment submitted?
A.) The eligibility assessment is inputted into the UAS through the Health Commerce System (HCS). To input assessments in UAS, assessors must be assigned a CMHA-40 role in HCS and complete all required UAS trainings

Q.) How often does a member need to be assessed?
A.) Members must be assessed annually. CMAs should track when assessments are due and schedule to complete re-assessment 1-2 months prior to the due date. CMAs should verify that the member is still HARP enrolled in ePaces prior to conducting a reassessment.

Q.) Does a member need to be enrolled in Health Home to receive the initial assessment?
A.) No, RCAs may assess members who are not enrolled in Health Home. RCAs must be contracted and credentialed with the MCO before assessing members. The MCO can introduce the benefits of HCBS to members and facilitate a referral to an RCA.

Q.) Can any agency perform the functions of an RCA?
A.) No, RCAs must be State Designated Entities and contracted with the member's MCO.

Q.) Can an agency use the results of an assessment completed previously by a separate RCA/CMA?
A.) Each agency must complete its own assessment. The agency that conducts the assessment should be the same entity that completes the POC/LOSR.

Q.) Who is qualified to conduct and submit the eligibility assessment?
A.) Staff must have at least a bachelor's degree in a qualifying field and at least two years' experience working with the behavioral health population. If staff have a masters in a qualifying field, then only one year of experience working with the behavioral health population is required. Qualifying fields include social work, psychiatry, nursing, education and many more. For a full list of qualifying fields, please see General Resources on the first page.

Q.) Can any staff member conduct and submit the eligibility assessment?

A.) Only qualified staff that have completed training within the UAS system can conduct an eligibility assessment. See link to required training in General Resources.

Best Practice: Some CMAs/RCAs have found it helpful to designate 1-2 staff members who are well versed in HARP and HCBS services to conduct the eligibility assessments for all HARP members. As an alternative, incorporating the eligibility assessment questions into Health Home comprehensive assessments has also been shown to prevent overloading members with multiple assessments.

Q.) What if I do not have staff that meet the qualifications?

A.) New York State Department of Health has a waiver form that can be completed online to allow staff members to qualify for conducting and submitting the eligibility assessment. A link to the waiver can be found in the general resources on the first page.

LEVEL OF SERVICE REQUEST (LOSR)

Q.) What is the best way to introduce HCBS services to a member?
A.) Services should be introduced to the member at the same time the assessment is completed.

Best Practice: Many CMAs have seen that members show a greater interest in HCBS when peers are used to introduce the services because they can often provide personal testimony to the value of HCBS (credible messengers with lived experience). Having HCBS providers conduct presentations can also increase interest in services. Ultimately, it is most important that the person presenting the member with information regarding HCBS is highly knowledgeable about the services and able to personalize how the services can benefit the member.

Q.) Does the LOSR qualify as a complete POC?
A.) The LOSR contains the minimum information necessary for a MCO to issue a LOSD so that a member can be referred to HCBS. After the member is connected to a HCBS provider a full POC must be completed and submitted to the MCO. The LOSR serves as a tool to rapidly connect members to HCBS, but all HARP members accessing HCBS must have a POC completed. Completed POCs include a comprehensive narrative, goals, services, signatures, and crisis plan.

Best Practice: When a LOSR is submitted for expedited connection, the POC should be completed after the first HCBS visit when provider supplies the ISP containing scope, frequency, duration of services.

Q.) What is RCA/CMA responsibility after submitting the LOSR?
A.) Once the MCO issues the LOSD, the CMA/RCA assists the member in identifying HCBS provider(s) and makes the referral to the provider of the client's choice. The role of the CMA/RCA is to help the client navigate the referral and intake process. Once the member is connected to HCBS services, the CMA/RCA is responsible for completing the final POC and submitting it to the MCO.

Best Practices: It is helpful for the CMA/RCA to serve as a bridge between the client and HCBS provider and, if possible, escort the client to their first intake appointment with the HCBS provider.

Q.) Is there a standard LOSR template accepted by all MCOs?
A.) The LOSR requirements are state standardized, but no universal LOSR submission template exists. Additionally, some MCOs accept LOSRs by phone. See subcommittee workflow grid.

Q.) Can the LOSR be reimbursed?

A.) No, the LOSR is not a reimbursable service. The assessment is reimbursable for Health Home members. The assessment and final POC are reimbursable for RCA members.

Q.) How do I know which HCBS providers to refer for approved services?

A.) The MCO will recommend two providers for each approved service, method of communication varies by plan see subcommittee grid. Member choice must be honored. It is helpful when CMAs establish relationships with HCBS providers and invite providers to conduct presentations to both care managers and clients. Some CMAs have used referral engines like NowPow to help identify HCBS providers in specific locations or with different specialties. These referral engines can provide a closed-loop referral system so that CMAs can receive feedback regarding referrals made. Providing feedback to the MCOs and the State regarding HCBS access and capacity issues is important so that MCOs can provide recommendations for HCBS providers that have capacity to immediately engage members. For a listing of HCBS providers in your designated arae visit: https://omh.ny.gov/omhweb/bho/provider-designation.html

INITIAL PLAN OF CARE (POC)

Methods of submitting LOSR/POC and HCBS Authorization vary by plan. For direct contacts and submission method by MCO see subcommittee grid. UAS cannot be used to submit POC.

Q.) Do all HARP members require a POC?
A.) HARP members requesting access to Home and Community Based Services (HCBS) must have a POC. The MCO may request a POC from the CMA/RCA at any time.

Q.) Are all sections of the POC required, including signatures?
A.) POC requirements are subject to CMS regulations. The POC must be signed by the member before submission to MCO.

Q.) Do all member status updates require a resubmission to MCO (ie. housing update)?
A.) A full POC submission is only required when new HCBS services are requested. If a BH HCBS needs to be added to the individual's POC, the care manager will need to submit an updated LOSR. 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 LOSD which the care manager will use to make BH HCBS referrals.

Q.) When should I hear back from the MCO about POC approval and HCBS providers?
A.) The MCO will review the request and issue a LOSD 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.

HCBS INTAKE VISIT(S) AND CONTINUED SERVICES

Q.) Does the HCBS provider update the plan of care?

A.) The CMA is responsible for documenting all updates to the POC and submitting it to the HCBS provider and MCO. The HCBS provider updates the ISP with the scope, frequency, and duration of services and sends to the CMA/RCA.

Q.) Is there a standard referral packet from the CMA/RCA to the HCBS provider?

A.) There is not a referral packet, but the CMA/RCA should share the LOSD with the provider. Generally, most HCBS providers request the initial plan of care, LOSD, and the eligibility assessment to be sent. There has been regional standardization to create a referral packet, but a universal statewide packet does not exist.

Q.) Will the member be admitted into HCBS after the first intake appointment?

A.) Often it takes multiple visits to assess the member, the HCBS provider has up to 3 visits in 14 days for initial intake. The RCA/CMA should follow-up with the HCBS provider to ensure successful intake.

Best Practice: The RCA/CMA should attempt to accompany the member to the intake appointment. In the event that this is not possible or would delay the intake appointment the RCA/CMA should provide the member with a reminder about the intake appointment prior to the appointment and follow up with the member and provider after the visit to confirm the client attended and stay informed of next steps.

Q.) If the HCBS provider determines a service not listed on the LOSD is most appropriate for the member, is a new LOSR required?

A.) Yes, the HCBS provider should contact the CMA/RCA to add the new service to the LOSR/POC for MCO approval. Once the CMA/RCA receives the updated LOSD from the MCO, they must submit the LOSD to the HCBS Provider.

Q.) Is an authorization required for the initial assessment visit(s), up to 3 in 14 days?

A.) An authorization is not needed for the intake visit, but the HCBS provider is required to "notify" the plan of the visit to configure billing systems. See HCBS subcommittee grid for plan-specific notification.

Q.) When does the HCBS provider submit the ISP?

A.) The ISP should be shared with the RCA/CMA as soon as the scope, frequency, and duration are established. Once the RCA/CMA receives the ISP containing scope, frequency and duration from the HCBS provider, the RCA/CMA will then be able to complete the POC and submit to the MCO.

Best Practice: Submit the ISP at the same time the authorization request is submitted to the MCO.