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To: All New York State (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 January 2022

Purpose

This guidance provides updated policy and operational guidance for Health Homes working to connect their HARP-enrolled and or HARP-eligible HIV SNP-enrolled members to Adult BH HCBS. Throughout the workflow described herein, the Health Home Care Manager (HHCM), the HARP and HIV SNP Plans (hereafter Managed Care Organization “MCO”), and BH HCBS provider(s) will all work to ensure members are given opportunity to understand the BH HCBS within their benefit package 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.

Beginning February 1, 2022, NYS will transition four (4) BH HCBS to a new service array called Community Oriented Recovery and Empowerment (CORE) Services; separate guidance and training will be issued to provide more details. For individuals wishing to receive services that are remaining as BH HCBS, the workflow outlined in this document will apply.

BH HCBS Workflow Guidance

As part of providing care coordination for an individual enrolled in a HARP or HIV SNP, the care manager will ensure the individual is informed of the BH HCBS benefits available to them, have a person-centered discussion with the individual about their recovery goal(s), and how BH HCBS may help achieve their goals. Adult BH HCBS include:

- Habilitation
- Education Support Services
- Pre-Vocational Services
- Transitional Employment
- Intensive Supported Employment Support
- Ongoing Supported Employment Support
- Non-Medical Transportation

For more information about each service, refer to the [NYS Health and Recovery Plan Adult Behavioral Health Home and Community Based Services Provider Manual](#).

In some situations, the individual may already be receiving a service - such as Personalized Recovery Oriented Services (PROS), Assertive Community Treatment (ACT), CORE, or Clinic - that meets their needs and cannot be combined with some BH HCBS.

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 Office of Mental Health (OMH) or Office of Addition Services and Supports) (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 on page six (6) of the [New York State Health and Recovery Plan \(HARP\) / Mainstream Behavioral Health Billing and Coding Manual for Individuals Enrolled in Mainstream Medicaid Managed Care Plans and HARPS.](#)

In other situations, the individual may be residing in a setting that is not considered home and community based (see NYS' [HCBS Final Rule Statewide Transition Plan](#) for more information), or decide they are not interested in receiving BH HCBS. The care manager will instead continue with the completion of required Health Home assessments, plans of care and referrals to other services that best address their health needs and goals, and are not duplicative.

When an individual expresses interest in BH HCBS, the workflow provided below shall be followed.

- **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 and education support services only), Tier 2 Eligibility (employment support services, education support, and habilitation), or No BH HCBS Eligibility.

Non-Medical Transportation services are available for eligible individuals under either Tier 1 or Tier 2.

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 eMedNY/Electronic Provider Assisted Claim Entry System (ePACES). Lead Health Homes must also ensure all Care Management Agencies are provided real-time access to HARP enrollment information for their members.

- Individuals will be identified with one of the following recipient restriction exception (RRE) codes:
 - H1 - HARP Enrolled
 - H4 - HIV SNP Enrolled, HARP Eligible
- If the NYS Eligibility Assessment determines an individual is eligible for BH HCBS, one of the following RRE 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 have met the NYS behavioral health high-need criteria. Individuals with an H9 and wishing to enroll in a HARP or HIV SNP may contact NY Medicaid Choice (NYMC) at 1-855-789-4277 for enrollment options.

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, a face-to-face assessment may include assessments performed via telehealth. For more information regarding BH HCBS requirements for independent assessment, see applicable regulations for 1915(i) services, at 42 CFR 441.720, under independent assessment.

If the individual is found not eligible for BH HCBS based on the NYS Eligibility Assessment results, the individual is unable to pursue BH HCBS which should be documented in the individual's record.

- **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 three (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 requires 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 (1) 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 POC 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 the 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. Once the BH HCBS provider has received authorization of scope, duration, and frequency of BH HCBS, the BH HCBS provider must notify the HHCM to add these details to the individual's POC and should also provide the ISP with the authorized scope, frequency, and duration to the HHCM. 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.

- **HHCM Completes and Submits the BH HCBS POC to the MCO**

The HHCM "holds" the overall POC, 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 and added. 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 POC to build on (per requirements of the Department of Health (DOH) Health Home Standards). Due to federal requirements associated with BH HCBS, there are additional key elements required within the POC for those receiving BH HCBS. The federal requirements for BH HCBS can be found here: [BH HCBS POC 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 POC 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 POC sign the POC. All other providers listed in the POC 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 POC, 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. If the POC is updated to reflect changes in BH HCBS, the revised POC 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 NYS Eligibility Assessment is valid for the period of one (1) year from the date of completion. Therefore, individuals receiving BH HCBS must have the assessment completed - at minimum - annually for all HARP members and HARP eligible HIV SNP members to determine functional impairment and continued need for BH HCBS, and/or after a significant change in the individual's condition *warrants a change be made to the individual's POC*. The POC shall be updated to reflect changes in the individual's needs, goals, BH HCBS eligibility, and/or services needed.

HHCMs are responsible for completing assessment and POC for individuals enrolled in a Health Home. If an individual opts out of Health Home care management, the MCO must ensure the individual is connected to a Recovery Coordination Agency (RCA) for ongoing assessment and care planning requirements for BH HCBS.

If you have any questions on the process, please contact the OMH Specialty Mental Health mailbox at SpecialtyMH_HHCM@omh.ny.gov; OMH Adult BH HCBS mailbox at Adult-BH-HCBS@omh.ny.gov; or submit questions to the [Health Home BML](#), subject "HARP".