

Adult BH HCBS Plan of Care Approval Workflow

for Individuals Enrolled in HARPs or HARP Eligibles Enrolled in HIV SNPs

December 2015

Key:

- **BH HCBS Eligibility Assessment**= subset of questions from NYS Community Mental Health Assessment and other BH HCBS eligibility questions
- **Full Assessment**= NYS Community Mental Health Assessment to help determine array of BH HCBS

A

Individual enrolled in a HH; Health Home Care Manager (HHCM) conducts NYS Community MH Assessments:

HHCM Conducts BH HCBS eligibility assessment¹
If eligible, HH Care Manager conducts Full BH HCBS assessment²

B

HHCM develops and submits Proposed Plan of Care (POC)³; MCO approves POC:

Individual and HHCM identify individual's goals. HHCM presents a menu of services inclusive of State Plan, BH HCBS, physical health services, community and natural supports that are supportive of goal(s), and driven by individual choice of services and providers.

HHCM may (but is not required to) include specific HCBS providers. HHCM records the services in the Proposed Plan of Care and submits to MCO (14 Days).

MCO approves POC⁴ and issues a LEVEL OF SERVICE Determination⁵ for BH HCBS listed in POC (3 Business days).

C

HHCM (with MCO) refer to BH HCBS providers:

BH HCBS Provider assesses for frequency, scope, and duration of service in collaboration with the individual.

Three visits/14 days will be paid for under the Level of Service Determination.

D

MCO authorizes BH HCBS and HHCM implements POC:

BH HCBS Provider contacts MCO to obtain PRIOR AUTHORIZATION⁴ for Frequency, Scope, Duration (3 Business days).

MCO sends BH HCBS Authorization Letter to HHCM and BH HCBS Provider.

BH HCBS provider contacts HHCM within 3 business days of receipt of Authorization to ensure engagement and scope of services.

HHCM updates and implements POC and shares with the MCO and the individual.

E

Monitor Ongoing Plan of Care:

HHCM/MCO monitors POC; ensures that individual is receiving BH HCBS reflected in POC; HHCM revises POC when necessary incorporating individual's input and choice⁶. When POC is revised MCO reviews and notification by the HHCM to the individual is required.

¹ The Eligibility Assessment can be done telephonically or face-to-face

² The BH HCBS full assessment must be done face to face. Eligibility and Full Assessments can be done in one face-to-face meeting if desired. Assessment process to be completed in 30 days as best practice, but not more than 90 days of Health Home enrollment unless the timeframe is extended by DOH as necessary for a limited period to manage the large number of assessments anticipated during the initial HARP enrollment period.

³ POCs that include recommended BH HCBS must meet Centers for Medicare & Medicaid (CMS) requirements and will include scope, duration and frequency of BH HCBS; individual must be given a choice of BH HCBS providers from the MCO's network and there must be documentation in the POC that choice was given to the individual.

⁴ MCO approval of the POC is not an authorization for services. 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).

⁵ Level of Service Determination and Prior Authorization for at least three provider visits must be completed within three (3) business days of receipt of necessary information, but no more than 14 days from the initial request and the extension of up to 14 days when specifically requested or justified in the enrollee's interest.

⁶ Every time the POC is updated it needs to be shared with the plan.

Step B

Level of Service Determination must be completed within three (3) business days of receipt of necessary information, but no more than fourteen (14) days after receipt.

B

HHCM develops and submits Proposed Plan of Care (POC);³ MCO approves POC:

Member and HHCM identify individual's goals. HHCM presents a menu of services inclusive of State Plan, BH HCBS, physical health services, community and natural supports that are supportive of goal(s), and driven by individual choice of services and providers. HHCM may (but is not required to) include specific HCBS providers. HHCM records the services in the Proposed Plan of Care and submits to MCO (14 Days).

MCO approves POC⁴ and issues a LEVEL OF SERVICE Determination⁵ for BH HCBS listed in POC (3 Business days).

B.1

Health Home Care Manager

1. Identifies with the individual their goal(s) and BH HCBS services that will support the member's goal (s)
2. Provides List of In-Network Providers for individual choice before or after Proposed Plan of Care is submitted
3. Submit Proposed Plan of Care to the plan for Level of Service Determination

B.2

MCO

1. MCO approves POC and issues a LEVEL OF SERVICE Determination and authorization for at least 3 visits to the BH HCBS listed in POC.
2. Level of Service Determination must be completed within three (3) business days of receipt of necessary information, but no more than fourteen (14) days after receipt.

BH HCBS Provider

No action Required



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Step C

The HCBS provider has 3 visits and 14 days from the 1st visit with the individual to assess and plan for frequency, scope, and duration of service.

C

HHCM (with MCO) refer to BH HCBS providers:

BH HCBS Provider assesses for frequency, scope, and duration of service in collaboration with the individual.

Three visits/14 days will be paid for under the Level of Service Determination.*

C.1

Health Home Care Manager

1. HHCM helps individual engage with In-Network BH HCBS provider of choice.

C.2

BH HCBS Provider

1. During first 3 visits/14 days the HCBS Provider assesses for frequency, scope, and duration of service in collaboration with the individual.

MCO

1. Continues to work with the HHCM, BH HCBS provider, and individual to offer support and further coordination.

*** Overall timeline can increase or decrease based on timeliness of referral engagement.**

Visits must comply with daily hour limits per the Billing Manual at:

<http://www.omh.ny.gov/omhweb/bho/billing-services.html>



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Step D

Prior Authorization must be completed within three (3) business days of receipt of necessary information, but no more than fourteen (14) days after receipt.

MCO authorizes BH HCBS and HHCM implements POC:

BH HCBS Provider contacts MCO to obtain PRIOR AUTHORIZATION⁴ for Frequency, Scope, Duration (3 Business days).

MCO sends BH HCBS Authorization Letter to HHCM and BH HCBS Provider.

BH HCBS provider contacts HHCM within 3 business days of receipt of Authorization to report on engagement and scope of services.

HHCM updates and implements POC and shares with the MCO and the individual.

D.1 BH HCBS Provider

1. BH HCBS provider contacts the MCO to notify of the initial assessment visits under the Level of Service Determination AND obtains Prior Authorization
2. BH HCBS provider contacts the HHCM within 3 business days of receipt of Authorization to ensure engagement and scope of services.

D.2 MCO

1. MCO approves service for frequency, scope, and duration.
2. Prior Authorization must be completed within three (3) business days of receipt of necessary information, but no more than fourteen (14) days after receipt.
3. MCO sends BH HCBS Service Authorization Letter to HHCM and BH HCBS Provider.

D.3 Health Home Care Manager

1. HHCM updates POC as necessary and shares with the individual and MCO.



Step E

On-going monitoring and care coordination with plan, providers, individual, and Health Home.

E

Monitor Ongoing Plan of Care:

HHCM/MCO monitors POC; ensures that individual is receiving BH HCBS reflected in POC; HHCM revises POC when necessary incorporating individual's input and choice. When POC is revised MCO reviews and notification by the HHCM to the individual is required.

E.1

Health Home Care Manager

1. HHCM updates Frequency, Scope, Duration of HCBS service into completed POC.
2. HHCM shares POC with MCO
3. Every time the POC is updated it needs to be shared with the plan.

E.2

BH HCBS Provider

1. Continues to provide services in accordance with POC to further engage individual in reaching their goal(s).
2. Periodic concurrent review with MCO.
3. On-going coordination with the HHCM.

