**Questions Received During 8/28 Applicant’s Conference**

| **#** | **Question** | **State Response** |
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|  | Are BH HCBS eligibility denials considered medical necessity denials that can be appealed to DFS external appeals or are they administrative denials that follow the path to fair hearing only? | These decisions are made pursuant to a State assessment tool and are not an MCO determination.  An enrollee or their representative may request a fair hearing to appeal decisions about eligibility for Behavioral Health Home and Community Based Services. |
|  | Are upstate Plans required to use MCTAC for trainings or is it optional? | MCTAC offers state funded training for providers. Additional Plan specific provider training should be coordinated through the RPCs. |
|  | Can the agencies allow attachments (for Bios) for all questions speaking to key staff/leadership? | Attachments for key staff/leadership bios are acceptable. |
|  | What codes will be used by health homes to bill plans for these BH HCBS assessments?  Are they in the billing manual? | Rate codes for the assessment are in the billing manual which can be found on the OMH website.  <http://omh.ny.gov/omhweb/bho/billing-services.html> |
|  | Is Mobile Crisis part of the mainstream plans?  Does short term and intensive services remain with HCBS? | Crisis intervention which is inclusive of mobile crisis is available to all individuals enrolled in Medicaid Managed Care.  Short term and intensive crisis respite remain as a BH HCBS. |
|  | Will the State reimburse the MCO for time at fair hearings?  Can fair hearings be conducted at MCO headquarters? | No changes will be made to the grievances and appeals process including the fair hearing process. See also 18 NYCRR Part 360-10.8 and the Medicaid Managed Care Model Contract Section 25. |
|  | What recourse is there for MCO’s whose Health Homes are unable to complete tasks or revise the POC, after MCO review and recommendations are given for revision? | The MCO should work with the Health Home to reach a resolution. If resolution cannot be reached the member can be reassigned to another Health Home.  NYS is in the process of revising the template ASA to clarify that an MCO can terminate its contract with a Health Home if the Health Home fails to follow MCO protocols, provided the Health Home is given 60 days to first remediate the issue. The MCO should only pursue this option if efforts to work collaboratively with the Health Home have not proved successful. |
|  | Are the Tier 1 & 2 accumulators calculated on an annual basis or a rolling 12 months?  If rolling, how is rolling defined? | NYS has determined that the BH HCBS Tier 1 and 2 accumulators will be calculated on a calendar year basis. |
|  | Can MCO’s refer members for HARP or does it have to rely on the state designation? | Currently HARP eligible individuals are identified by the State. NYS is developing a process for community referrals. |
|  | Will the medical necessity guidelines be finalized before the upstate RFQ due date? | NYS has guidance documents related to UM for HCBS (developed in collaboration with HPA), SUD services (use of LOCATDR), ambulatory office and clinic services, Assertive Community Treatment, and Personalized Recovery Oriented Services (PROS).  These documents are available to all plans.  NYS will not issue guidance on UM for any other services. |
|  | Does the BH HCBS designation have a term?  Does any entity have to re-designate annually or by some other timeframe? | Designation is not for a particular timeframe, however the applicant will have to continue to meet the requirements established.  NYS is in the process of developing BH HCBS oversight guidelines to ensure that services are provided in accordance with the BH HCBS manual. |
|  | How will plans know when the previous evaluations for BH HCBS was done for members who came from another plan, as eligibility needs to be evaluated annually? | Through the UAS, Plans will be able to see previous assessments that were completed. |
|  | Would the state provide the codes necessary to properly identify providers by services for the plans network submission?  (i.e. need updated HPN data dictionary) | For the initial network development, the State will provide a list of providers that serve 5 or more of their members. Plans must offer contracts to these providers. Additionally, the state will also provide the list of essential community providers for which the Plans must contract (i.e., OTP and state operated outpatient programs) |
|  | Can MCO staff administer the InterRAI and develop the plan of care with the Health Home? | This proposed approach conflicts with NYS’s approach for conflict free care management. The State continues to work with Plans and Health Homes to facilitate their partnership in the development of effective plans of care. |
|  | Does the RFQ question need to be included with the reply, and if so does it apply to the page limit? | Yes, Please identify the question that you are providing a response to. You will not be penalized on page limit for including the question. |