Adirondack Health Institute

Lead Empower Innovate

POLICY AND PROCEDURE

Title: HARP Oversight Policy

Department: Health Home

Intended Population: Health Home Serving Adults

Effective Date: 5/1/2019

Review Date: 12/10/2020

Date Revised: 12/10/2019

Purpose of Policy

To establish standards and guidance regarding the management and oversight of the additional requirements for serving the HARP population in Health Home.

Scope

This policy applies to all AHI Health Home Service Providers that serve Health Home participants enrolled or eligible for a HARP.

Statement of Policy

AHI shall develop, disseminate, and review at least annually a HARP Oversight Policy that addresses purpose, scope, roles and responsibilities, management commitment, coordination among organization entities, and compliance. AHI shall formalize documented procedures to facilitate the implementation of the HARP Oversight Policy.

Definitions

AHIHH: AHI Health Home, a designated lead Health Home by the New York State Department of Health

Health Home Network Partners: The group of medical, behavioral, social services, and other community-based organizations by which a Health Home Participant receives services to address needs identified on the comprehensive care management plan developed by the Health Home Participant's AHI Health Home Services Provider.

Health Home Participant: A Health Home Candidate who is participating in the AHI Health Home and is assigned to an AHI Health Home Services Provider for care management.

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Health Home Service Provider: An organization that has a fully executed contract (the "Health Home Services Provider Agreement") with the Adirondack Health Institute to provide health home outreach and/or care management services.

Care Management Record System: A structured information system, maintained by the Adirondack Health Institute Health Home (AHIHH), and made available for Health Home Service Providers and Health Home Network Partners to utilize, as applicable and appropriate to their role in the Health Home.

Core Health Home Services: The list of five (5) approved categories of services for which a Health Home Care Management Agency can be paid, as defined by the New York State Department of Health:

- Comprehensive Care Management
- Care Coordination & Health Promotion
- Comprehensive Transitional Care
- Member & Family Support
- Referral and Community & Social Support Services

Note: the sixth category of Core Health Home Services, "The use of HIT [Health Information Technology] to link services, as feasible and appropriate," is NOT considered a billable activity.

RHIO: Regional Health Information Organization

HARP: Health and Recovery Plan

HCBS: Home and Community Based Services are available for people 21 and over who are enrolled in a Medicaid Managed Care Health and Recovery Plan (HARP) and found eligible after completing the HCBS Eligibility Assessment. People enrolled in a Special Needs Plan (SNP) may also be eligible for HCBS.

- Psychosocial Rehabilitation
- Community Support and Treatment (CPST)
- Habilitation Services
- Family Support and Training
- Short-Term Crisis Respite
- Intensive Crisis Respite
- Education Support Services
- Peer Support Services
- Non-medical Transportation
- Pre-vocational Services
- Transitional Employment
- Intensive Supported Employment
- On-going Supported Employment

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Brief CMHA: Community Mental Health Assessment

UAS: Uniform Assessment System

Background

The HARP Oversight Policy at AHI is intended to facilitate the effective implementation of the processes necessary to meet the Health Home Program standards and requirements as stipulated by the NYS DOH, federal regulations, and best practices. This policy directs that AHI meet these requirements.

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It is the policy of Adirondack Health Institute Health Home (AHIHH) that we work with each HARP eligible client to assure they understand the benefits of HARP, and if they desire, to assist them to enroll in HARP. It is also the policy of the AHIHH that each Health Home member receives the HCBS eligibility assessment in the UAS **within the first 90 days of enrollment and annually thereafter, to establish their tier of eligibility for HCBS services.** Each CMA must complete the HCBS assessment for each HARP enrolled member as part of the Health Home assessment process. Each CMA that has under a 75% completion rate of HARP assessment may be subject to a Corrective Action Plan. AHIHH will monitor the completion of the HCBS eligibility assessment though maintaining the Health Home Case List in the NYS DOH Uniform Assessment System (UAS).

Procedure

A Health and Recovery Plan (HARP) is a Medicaid managed care insurance plan that manages physical health, mental health, and substance use services in an integrated way for adults with significant behavioral health and substance use service needs. HARP plans also manage an enhanced benefit package of Home and Community-Based Services (HCBS) for eligible enrollees. HCBS provides opportunities for HARP members to receive rehabilitative and recovery services in their own home or community.

HARP Eligibility

Health Home Service providers should verify Medicaid eligibility and HARP enrollment status as a first step to verifying HARP eligibility.

- HARP eligibility is based on certain factors, such as past use of behavioral health services in Medicaid. NYS DOH generates an updated list of people who are eligible for HARP every other month.

- HARP eligibility status appears in the e-PACES system as a restriction/exception code. Individuals can ask their treating providers to look up their eligibility status or they can call New York Medicaid Choice at 1-855-789-4277; TTY users: 1-888-329-1541.
- HARP eligibility and enrollment status is indicated by the restriction/exception codes that begin with the letter "H". *See HARP eligibility H codes on page 12*
- 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.

Reasons why a HARP-eligible person may not be enrolled in a HARP

A HARP eligible individual may not currently be enrolled in a HARP for the following reasons:

- HARP enrollment may be pending and will become effective at a future date.
- The individual previously chose ***not*** to enroll in a HARP, otherwise known as "opting-out" of HARP enrollment.
- The individual's address has not been updated with Medicaid, causing HARP enrollment notices sent by New York Medicaid Choice to be returned.
- The individual enrolled in Medicaid through or recertified Medicaid eligibility through New York State of Health (NYSoH2), sometimes referred to as the "Exchange" or "Marketplace." New York Medicaid Choice can assist these individuals who wish to enroll in HARP.
- The individual was disenrolled from HARP upon losing Medicaid eligibility, possibly due to failure to recertify. Note that an individual in this circumstance must first contact the Local Department of Social Services (LDSS) to reestablish Medicaid coverage in order to enroll or reenroll in HARP.
- The member is enrolled in both Medicaid and Medicare a.k.a. "dual eligible".

Whenever possible, individuals should be assisted in maintaining Medicaid eligibility through timely recertification to avoid loss of Medicaid coverage and HARP enrollment.

HARP Enrollment Process

HARP enrollment is conducted by New York Medicaid Choice. The individual will need to have the following information when contacting New York Medicaid Choice:

- Medicaid Client Identification number (CIN) or social security number (SSN)
- Full name
- Date of birth
- Home address and telephone number, if available.

Eligible individuals (H9) may choose to enroll in a HARP at any time, even if the individual previously chose to opt out or never received an enrollment notice. HARP enrollment is voluntary, and eligible

individuals may contact New York Medicaid Choice to learn about available enrollment options. HHSP's can assist members through this process.

To determine HARP eligibility and assist with HARP enrollment:

1. Check e-PACES and verify the Medicaid case has been assigned an "H9" code. If the case does not have an H9 code, the individual is most likely not eligible to enroll in a HARP.

2. If the Medicaid case has an "H9" code, the individual should contact New York Medicaid Choice to elect HARP enrollment. The provider and/or the individual's representative may assist the individual in contacting New York Medicaid Choice. The individual must be present on the call and specifically request New York Medicaid Choice to enroll him or her in a HARP.

3. New York Medicaid Choice will work with the individual to determine the plan of choice and activate HARP enrollment. New York Medicaid Choice will notify the individual of the effective date of the HARP enrollment.

Qualifications for Care Managers Conducting the HCBS Eligibility Assessment

Education

1. A Master's degree in one of the qualifying fields and one years of experience; OR
2. A Bachelor's degree in one of the qualifying fields and two years of experience; OR
3. A Credentialed Alcoholism and Substance Abuse Counselor (CASAC) and two years of experience; OR
4. A Bachelor's degree in ANY field with either: 3 years' experience or two years' experience as a Health Home Care Manager serving the SMI or SED population

AND

Experience Must Consist of

1. Providing direct services to people with Serious Mental Illness, developmental disabilities, alcoholism or substance abuse, and/or Children with SED; OR

2. Linking individuals with Serious Mental Illness, Children with SED, developmental disabilities, and/or alcoholism or substance abuse to a broad range of services essential to successful living in a community setting (e.g. medical, psychiatric, social, education, legal, housing, and financial services.)

**Qualifying education includes degrees featuring a major or concentration in social work, psychology, nursing, rehabilitation, education, occupational therapy, physical therapy, recreation or recreation*

therapy, counseling, community mental health, child and family studies, sociology, speech and hearing or other human services field.

AND

Supervision

Supervision from someone meeting and one of the following

1. Licensed level healthcare professional with prior experience in a behavioral health setting; OR
2. Master´s level professional with two years of supervisory experience in a behavioral health setting.

Licensed level healthcare professional includes: Physicians, Psychiatrists, Physician's Assistants, Nurse Practitioners, Psychiatric Nurse Practitioners, Registered Professional Nurses, Licensed Practical Nurses, Licensed Psychologists, Licensed Clinical Social Workers, Licensed Master Social Workers, Licensed Mental Health Counselors, Licensed Marriage and Family Therapists, Licensed Psychoanalysts, Licensed Creative Arts Therapists, and Licensed Occupational Therapists.

Waiver Request of Adult BH HCBS Assessor Qualifications

In rare circumstances, staff may have unique education and/or experience to adequately serve the high need behavioral health population but do not meet the updated qualifications outlined in this memo. HH CMAs and contracted RCAs may apply for a waiver for such staff.
Waivers are not intended to be the sole approach for an agency looking to expand capacity in serving these populations. Agencies should be prudent in selecting staff to pursue a waiver of qualifications. Waivers should only be submitted for those staff whose unique qualifications allow them to adequately serve the population.

Training

1. Specific training for the designated assessment tool(s), the array of services and supports available, and the client–centered service planning process. Training in assessment of individuals whose condition may trigger a need for HCBS and supports, and an ongoing knowledge of current best practices to improve health and quality of life.
2. Mandated training on the New York State Community Mental Health Assessment instrument and additional required training.

   Information regarding accessing these trainings are available upon request.

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HCBS Workflow

The overall timeframe allowed to complete the HCBS Eligibility Assessment to submitting a Plan of Care inclusive of HCBS to the Managed Care Organization- shall be thirty (30) days 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. *Also See Appendix B*

NYS Eligibility Assessment

HHSPs will use the NYS Eligibility Assessment to determine if HARP members are eligible for Adult HCBS. The NYS Eligibility Assessment will determine Tier 1 Eligibility (employment, education, and peer support services only), Tier 2 Eligibility (full array of HCBS), or No HCBS Eligibility.

The HCBS Eligibility Assessment must be completed face-to-face with the member. The HHSP should initiate the HCBS Eligibility Assessment as soon as they receive a new member assignment (for example, using this tool as part of an intake process). If the member was enrolled in Health Home prior to their enrollment in the HARP or HIV SNP, the HHSP will have 30 days, but no more than 90 days, from member's HARP or HIV SNP enrollment date to complete the HCBS Eligibility Assessment.

There are circumstances that will result in the individual *not* pursuing HCBS after completing the NYS Eligibility Assessment. In these scenarios, the HHSP would not move forward with the remaining workflow described in this policy but will instead continue to work with the individual in their role as a HHSP 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 HCBS based on the NYS Eligibility Assessment results.
2. Individual is found eligible for HCBS but does not feel HCBS will help them reach their identified life role goal.
3. Individual is found eligible for HCBS but chooses to remain in a State Plan service already meeting their need(s).
4. Individual is found eligible for HCBS and resides in a setting that is not considered home and community based. **If the member later moves to an eligible setting, the care manager should ensure an NYS Eligibility Assessment has been completed and begin the process to connect the individual to HCBS (if the individual chooses)**. Ideally this process will start early enough to allow the individual to begin to receive HCBS immediately upon entering the eligible setting.

If the individual is not pursuing HCBS for any of the reasons described above, HHSPs will document this within the UAS assessment platform, 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.

If a member would like to receive an HCBS service that is not available in their geographic region, the HHSP should contract AHIHH to alert the members MCO of the gap in services. HHSP's can contact AHIHH by emailing healthhome@ahihealth.org.

Person-Centered Discussion about the Individual's Recovery Goal(s)

The HCBS eligibility assessment shall prompt a person-centered discussion with the individual about their recovery goal(s), and how 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), or clinic services that meets their needs and cannot be combined with some HCBS or the member may not be interested in receiving HCBS. The HHSP should help the individual make an informed choice about which available services best addresses their health needs and goals.

Level of Service Determination for HCBS

After the HHSP completes the NYS Eligibility Assessment and determines that the individual is eligible for and interested in a referral to HCBS, the **HHSP submits a HCBS Level of Service Determination request to the member's MCO**. *Please refer to MCO contact list in Appendix A*. This request may be made in a written or verbal format, as agreed to by the MCO and the HHSP. At minimum, the request shall include the following information:

1. 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 HCBS recommended.

The MCO will review the request and issue a Level of Service Determination (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. If the MCO approves the Level of Service request, the Level of Service Determination will include confirmation that the level of HCBS proposed for the individual is appropriate. The MCO may issue one Level of Service Determination for all HCBS proposed when more than one 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 HCBS proposed by the HHSP. 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 HHSP 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 HCBS service 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 HCBS should be included so the MCO can review the full package of HCBS services. The MCO will issue a new Level of Service Determination, which the care manager will use to make HCBS referrals.

Individuals must be given a choice of 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 HHSP shall ensure that when assisting the individual in choosing a 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 HCBS

The HHSP should ensure referrals are made in a timely fashion after the LOS Determination is approved 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.

Upon receipt of the MCO's Level of Service Determination, **the HHSP makes a referral for HCBS to the individual's choice of provider(s).** With proper consent, the HHSP 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 HCBS provider(s).

The HCBS provider may request additional documentation; however, the provider should be aware that the member'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 HCBS Providers

Upon receiving the referral from the HHSP, each 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 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 HCBS. If more time or visits are needed, the HCBS provider must notify the MCO and request authorization for additional time/visits needed.

HCBS Authorization of Ongoing HCBS

After the HCBS provider completes the intake/evaluation (or the first 3 visits, whichever comes first), to request MCO authorization to provide ongoing HCBS, the HCBS provider must submit the 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 HHSP, HCBS provider, and the member of the determination.** If the MCO denies or partially approves the services requested by the HCBS provider, the MCO must issue an initial adverse determination with applicable appeal and fair hearing rights. Once the HCBS provider has received authorization for scope, duration and frequency of HCBS, the HCBS provider must notify the HHSP to add these service elements to the individual's Plan of Care.

HHSP Completes and Submits the HCBS Plan of Care to the MCO

The HHSP maintains the members Plan of care, which is driven by the individual's life and recovery goal(s). HCBS, behavioral health, medical, community and social supports all help to support that individual in reaching their goal(s), and therefore should be included in 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 HHSP shall work with family, supportive friends, providers, and the MCO, as applicable, to assist in the development of the POC. The POC, inclusive of HCBS, is the framework for communicating the individual's service needs between the HHSP, the 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 HCBS, there are additional key elements required within the Plan of Care for those receiving HCBS. Many of these additional elements are collected by the HHSP as part of the standard Health Home comprehensive assessment process.

As a best practice, we encourage that members be given the opportunity to sign the POC whenever it is revised. However, **at a minimum, the individual must sign the POC prior to submitting the completed POC to the MCO**.

The HHSP shall ensure that all HCBS providers listed in the Plan of Care participate 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 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 in the members care management record. 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 HHSP will submit the POC to the MCO.

The MCO will monitor for timely completion of the HCBS NYS Eligibility Assessment and POC and may work with Health Homes to improve any quality issues, such as unnecessarily delayed assessments or incomplete plans of care. The MCO will work with the HHSP as needed to ensure POCs are comprehensive, integrated, person-centered, and that the 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 delays in the completion of Plans of Care and/or other documentation required. If the Plan of Care is updated to reflect changes in HCBS, the revised Plan of Care should be shared with the MCO.

Ongoing Monitoring of the POC

HHSPs 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 HCBS eligibility is required for all HARP members and HARP-eligible HIV SNP members to determine functional impairment and continued need for HCBS, including for those previously deemed not eligible for HCBS at their last assessment.

The HHSP 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, HCBS eligibility, and/or service needs.

Resources

New York Medicaid Choice

New York Medicaid Choice is the State's enrollment broker and is available to assist individuals with plan enrollment. Individuals who have any questions about HARP eligibility and how to enroll or requires additional information about how a HARP may be beneficial, may call **New York Medicaid Choice at 1-855-789-4277 TTY users: 1-888-329-1541.** New York Medicaid Choice counselors are available to assist in all languages. Individuals may ask a representative or someone they trust to aid when calling New York

Medicaid Choice. New York Medicaid Choice staff are trained to assist individuals and the individual's provider or other representative who are seeking information regarding HARP enrollment options.

Independent Consumer Advocacy Network (ICAN)
Individuals or their representatives can also contact the **Independent Consumer Advocacy Network (ICAN),** which provides free, confidential help to individuals who are eligible for or enrolled in HARPs. ICAN can help individuals decide whether HARP is right for them, answer their questions about their benefits, provide advice and information, and advocate for them in the appeals process. For additional information, please contact:

ICAN at 1-**844-614-8800** or **email** ican@cssny.org.

ICAN is the NYS Ombudsman Program for people with Medicaid who need long term care services or behavioral health services.

HARP H Codes and Description

H1	HARP enrolled without HCBS eligibility
H2	HARP enrolled with Tier 1 HCBS
H3	HARP enrolled with Tier 2 HCBS
H4	HIV SNP HARP eligible without HCBS eligibility
H5	HIV SNP HARP eligible with Tier 1 HCBS
H6	HIV SNP HARP eligible with Tier 2 HCBS
H9	HARP eligible pending HARP enrollment

Quality and Performance Improvement

AHIHH will review HARP compliance monthly. Quality assurance indicators may include:

- Completion of the HARP Assessment within in the first 90 days of enrollment
- HARP assessment is administered annually
- Assessment results are uploaded into the EHR
- Completion and submission of the HARP POC for those member's pursuing HCBS services
- Member's choice not to pursue HCBS services are noted in the HH POC

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Training:

This policy will be disseminated for review and questions before a policy training is given. If more time is needed outside of the initial policy training, a future in-depth training will be developed and/or identified for Health Home Care Managers to gain an understanding of the HARP workflow and Evidence-based methods for increasing engagement including; Motivational Interviewing, Recovery-Oriented Practices, Person-Centered Panning. Trainings regarding the HARP Plan of Care, and HARP Assessment will also be given/found by the Health Home.

Contact Person: Director, Health Home and Care Management

Responsible Person: Health Home Service Provider

Approved By: Chief Operating and Compliance Officer

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Appendix A: MCO Contacts

MCO Contacts

HARP Members

- Please submit the HCBS Service Level Request along with the Member's consent listing the MCO to the Member's MCO.
  - When submitting the Preliminary POC to CDPHP, please include the separate CDPHP-specific consent required by CDPHP.
  - For MVP Members, the DOH-5055 must list Beacon Health Care Options as well as MVP.

MCO	Preliminary POC Submission		Contacts for HARP/HCBS Questions	
	Secure Email	Secure Fax	Name/Department	Contact
CDPHP	N/A	518-641-3601	HARP Access Center	518-641-3600
			John M. Arcuri, Manager Behavioral Health	518-641-3485 jarcuri@cdphp.com
			Jeremy Boyce, Team Lead	518-641-3492
			Nick Lansing	518-641-3397
Fidelis	QHCMHARPBH@fideliscare.org	347-868-6427	Eric Lantier, HCBS Compliance Manager	elantier@fideliscare.org 718-896-6500 ext. 60854
			Health Home Dedicated Phone Line	877-881-6895
			CMHA Helpdesk	734-930-0855
			HARP Dedicated Phone Line	888-343-3547 ext. 16077
			HARP Enrollment Line (H9)	888-343-3547 ext. 16179
MVP/Beacon Health Care Options for HARP	Preferred Method: Tarrytownbeacon@BeaconHealthOptions.com Subject Line: MVP Plan of Care	781-994-7136 Attn: MVP Plan of Care	Zelesther Cay, LMSW, RN-BC, Director of Clinical Services	781-496-4075
			Kevin.Dame@beaconhealthoptions.com Case Management Clinical Supervisor	518-220-8605
			Danielle.Kleveno@beaconhealthoptions.com HARP Intensive Case Manager	781-994-7502
			Lissette.Rodriguez@beaconhealthoptions.com HARP Intensive Case Manager	646-927-4232
			Lyndsay.DeFeo@beaconhealthoptions.com HARP Intensive Case Manager	585-259-8797
			Chloe.Tibbitts@beaconhealthoptions.com HARP Care Coordinator	518-220-8735
United Healthcare	NYHARPAuthorizations@uhn.com	N/A		

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Appendix B