Bassett Healthcare Network
Community Health Navigation

Policy/Procedure:	Health Home Requirements for HARP Members
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I. Policy:

Bassett Community Health Navigation and Partnering Care Management Agencies will ensure that Members enrolled in Health and Recovery Plans (HARP) will be educated about their status and advised of the array of Home and Community Based Services (HCBS) that are potentially available to them. Bassett CHN Care Managers will ensure that the Behavioral Health HCBS Eligibility Assessment and subsequent service engagement process is completed in accordance with required timeframes for those who are eligible and requesting access to HCBS services. Partnering Care Management Agencies will be responsible to ensure that compliance with all HARP and HCBS requirements are maintained within specified levels of performance.

***CHN refers to Bassett Community Health Navigators & Partnering Health Home Care Managers**

Quality Management and Performance Improvement

Bassett CHN will review HARP compliance monthly. Quality assurance indicators may include (but not limited to):

Completion of the HARP Assessment within in the first 90 days of enrollment HARP assessment administered annually

Assessment results 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

Monthly Complex Case Reviews will be completed, by Bassett CHN Clinical Network Staff, to insure members are receiving appropriate standards in care (gaps, chronic conditions, etc)

- Each CMA that has under a 75% HARP Assessment completion rate may be subject to a corrective action plan (CAP) or Performance Improvement Plan (PIP). Bassett CHN will monitor the completion of the HCBS Eligibility Assessment, through maintaining the health home case list in the NY State DOH Uniform Assessment System (UAS).

HH. Procedures:

A. Requirements for Health Home Members identified as HARP-enrolled

1. CHN (or designated CMA staff) must verify Health Home Members' Medicaid status and Restriction-Exception codes each month to determine if the Member is enrolled in a HARP plan or if there are any changes in a Member's HARP status. If so do the following:

a. 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.

i. 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. **New York Medicaid Choice at 1-855-789-4277 TTY users: 1-888-329-1541**

ii. 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.

iii. Dual-eligible Members (those with Medicare and Medicaid) are not eligible for HCBS and should not be counted as HARP-enrolled for the purposes of these procedures

b. CHN must notify their CMA HARP Supervisor/Team-Leader of any of the following changes in a Member's HARP status for tracking purposes:

i. Health Home enrollment of HARP-enrolled Member
ii. Loss of HARP-enrolled status

c. CMA Supervisors/Team Leaders will update the Member's Program in the Care Management Record as follows:

i. For HARP-enrolled Members being enrolled in Health Home: Add HARP-enrolled Program with Start Date as Date of Health Home Enrollment
ii. For Health Home Members who subsequently become HARP-enrolled: Add HARP Program with Start Date as: First day of Month of HARP-enrolled status
iii. For Health Home Members whose status changes from HARP-enrolled to non-HARP-enrolled: Edit HARP-enrolled Program with End Date as Last Day of Month of HARP-enrolled status

2. CHN must complete the following requirements for HARP-enrolled Members at the time of Health Home Enrollment (or upon a Health Home Member becomes HARP-enrolled/HARP eligible):

a. Educate the Member on their status as HARP-enrolled and the array of HCBS services which may be available to them if they are determined eligible by assessment, and how those services may meet the Member's identified needs.

i. CHN may utilize the following resources to help educate Member (available on Bassett CHN website:
a) DOH HARP-HCBS Brochures
b) DOH HARP-HCBS Educational Videos
c) Bassett CHN HARP-HCBS Guide

b. Complete a DOH-5230: Functional Assessment Consent with the Member, indicating their choice to consent to or decline the HCBS Eligibility Assessment
c. Complete documentation in the Member's Care Management Record:
i. Note must include the following details:

a) Member was educated on HARP status and the HCBS services potentially available
b) Member's decision to complete or decline the HCBS Eligibility Assessment (include reasons for declination if Member declines)

ii. Upload completed DOH-5230 to Member's Documents Tab

iii. If Member declined HCBS Assessment, complete a General Assessment in the Assessments Tab as follows:

a) Assessment Date: Date Member declined assessment/completed DOH-5230 as "declined"
b) Assessment Type: "HCBS Eligibility Assessment Declined"
c) Score: "NA"
d) Comments: Reason for declination
e) Substantiating note should explain reason why member declines and personal preference.

3. The BH HCBS Eligibility Assessment must be completed with the Member within 30 days of Health Home enrollment (or subsequent HARP-enrollment).
   a. The HCBS Eligibility Assessment must be incorporated into the Comprehensive Assessment process for HARP-enrolled Members being enrolled in Health Home
   b. HCBS Eligibility Assessments must be conducted Face to Face by HARP qualified and trained staff (see Bassett CHN Staff Qualification & Training Requirements Policy)
   c. HARP Qualified & Trained Staff completing the HCBS Eligibility Assessment with the Member must ensure the appropriate consents are completed with the Member before conducting the assessment or accessing the Member's Case File Records in UAS-NY:

i. Prior to completing assessment: DOH-5230 Functional Assessment Consent indicating the Member consents to assessment
ii. Prior to accessing Member's UAS-NY Case File:
a) DOH-5032: Authorization for Release of Health Information (Including Alcohol/Drug Treatment and Mental Health Information) and Confidential HIV/AIDS-related Information; OR
b) DOH-5055 updated to include "UAS-NY" on page 3

c) HCBS Eligibility Assessments must be entered, signed, and locked in UAS-NY to be considered complete.

d) After the HCBS Eligibility Assessment has been completed:

iii. If HCBS Eligibility Results indicate that the Member is eligible for Tier 1 or Tier 2 HCBS, and the Member chooses to receive HCBS services, the CHN must complete the following:
a) Engage the Member in person-centered discussion about their needs and goals to determine the specific HCBS services that will be requested based on the Member's Tier-level eligibility.

iv. Complete the following documentation in the Member's Care Management Record:
   a) Note must include the following details:
      i.) Any significant details of completing assessment
      ii.) The Member's decision regarding HCBS Services
      (If Member declined, include reasons for declining services)
      iii.) The specific HCBS Services and Goals determined
   b) Upload the following documents, as applicable:
      i.) DOH-5230 Functional Assessment Consent indicating Members consent to complete assessment
      ii.) DOH-5032 Release for Sharing Information OR
      iii.) DOH-5055 with UAS-NY specified as consented
      iv.) HCBS Eligibility Assessment Results Summary from UAS-NY
   c) Complete a General Assessment in Assessment Tab, including the following details:
      i.) Assessment Date: Date assessment completed
      ii.) Assessment Type: "HCBS Eligibility Assessment Completed"
      iii.) Score: As follows, depending on eligibility and decision:
         - Tier 1-Requesting HCBS
         - Tier 2-RequestingHCBS
         - Tier 1-Declining HCBS
         - Tier 2-Declining HCBS
         - Not Eligible
      iv.) Comments: If Member is declining HCBS services after assessment, enter the Member's Reasons for declining

4. If the Member is eligible for and requesting HCBS services, the following steps must be completed within 90 days of Health Home Enrollment or designation as HARP-enrolled:
   a. Complete an HCBS Level of Service Request including the following information:
      i. If using HCBS Plan of Care Template, the following sections need to be completed for submission as a Level of Service Request:
         a) Section 1: Demographics
         b) Section 2: Current Providers & Services
         c) Section 3: HCBS Tier Level Eligibility
         d) Section 4: HCBS Services Requested
         e) Section 5: Interventions
         f) Section 6: Goals/Preferences/Outcomes/Strengths for each requested service
         g) Section 8: Affirmation, Release Consent, and Signatures

      ii. If using Netsmart HCBS Level of Service Request, the following sections need to be completed:
         a) Housing Questionnaire
         b) Services Requested
         c) Past Efforts, Preferences, Outcomes & Barriers for each requested service
         d) Choice of HCBS or Access-VR for Selected Services
         e) Goal Statement
         f) Signatures

b. Submit the completed Level of Service Request and other required documents to the Member's MCO, as specified in the Bassett CHN HARP/HCBS MCO Approval Protocol
    i. Complete the following documentation in the Member's Care Management Record:
        a) Complete Note detailing submission of LOSR
        b) Upload LOSR to Attachments (if not completed in Netsmart)
        c) Complete General Assessment in Assessment Tab, as follows:
            i.) Assessment Date: Date LOSR Submitted to MCO
            ii.) Assessment Type: "HCBS LOSR submitted to MCO"
            iii.) Score: Abbreviations of HCBS Services being requested
c. Upon receiving Level of Service Determinations from the Member's MCO:
    i. Complete documentation in the Member's Care Management Record:
        a) Complete Note detailing receipt of LOSD
        b) Upload all Level of Service Determinations to Documents Tab
        c) Complete General Assessment in Assessments Tab, as follows:
            i.) Assessment Date: Date LOSDs received
            ii.) Assessment Type: "HCBS LOSD received from MCO"
            iii.) Score: Abbreviations of HCBS Services approved
d. If a choice of HCBS providers is available, discuss the available options with the Member, providing Member with information, brochures, etc. for each agency, so that the Member may make an informed decision to select HCBS Providers.
    i. The discussion and Member's resulting choice must be documented in Notes

e. CHN will then submit referrals to the selected HCBS providers and assist as necessary to coordinate with the Member and HCBS providers throughout HCBS provider screening & assessment process.
    i. Selected HCBS Providers will complete additional assessments and develop an HCBS Individual Service Plan (ISP) that includes the Scope, Duration, and Frequency of each selected HCBS service.
    ii. HCBS providers will submit ISP and Authorization of HCBS Services Request to the Member's MCO for approval.
    iii. Once HCBS Individual Service Plans (ISPs) have been approved by the MCO, CHN will obtain a copy of each ISP from the HCBS Provider(s), which will include the approved Scope, Frequency, and Duration of each HCBS service.

f. CHN will complete a Full HCBS Plan of Care, including the following information:
    i. Scope Frequency & Duration for each service requested/approved service
    ii. Crisis Plan
    iii. Natural Disaster Plan
    iv. Backup Plan
    v. Risk Assessment (Only if Needed on individual basis)
    vi. Affirmation, Release Consent & Signatures
g. Submit copies of the updated/full HCBS Plan of Care to the following parties:
    i. Member's MCO
    ii. Each HCBS Provider
    iii. Member and Caregivers/Social Supports as requested

h. Complete documentation in the Member's Care Management Record:
    i. Complete Note detailing specific parties HCBS Care Plan was sent to
    ii. Upload Full HCBS Plan of Care to Documents
    iii. Complete General Assessment in Assessments Tab, as follows:
        a) Assessment Date: Date HCBS Plan of Care sent to MCO
        b) Assessment Type: "HCBS Plan of Care Submitted to MCO"
        c) Score: Name of MCO (or "Fee for Service')
        d) Comments: List each HCBS service along with scope, duration, frequency and HCBS Provider for each service

5. CHN will continue to monitor and assist the Member's engagement with HCBS services on an ongoing basis to facilitate receipt of services
    a. Upon confirmation that Member has started receiving services from HCBS Providers, CHN will complete a General Assessment in the Assessment Tab as follows:
        i. Date of Assessment: Date of Full HCBS services starting
        ii. Assessment Type: HCBS Receiving Services
        iii. Score: Abbreviations of HCBS Providers Member is receiving services with
        iv. Comments: Any additional information relevant to engagement/receipt of services
    b. CHN will update the Member's HCBS Plan of care accordingly as goals change or if services are added or discontinued.
        i. CHN will send updated Plans of Care to MCO, HCBS Providers (and Member if requested)
        ii. CHN will upload updated Plans of Care to Attachments

6. HARP-enrolled Members must have all HARP procedures completed and documented annually (within 12 months of last occurrence) as part of the Annual Eligibility & Comprehensive Assessment Process or anytime there is a significant change to the

   Member's needs or level of functionality related to their condition(s).
    a. A new DOH-5230 must be completed each time the Member completes an HCBS Eligibility Assessment

B. HARP Compliance Requirements for Partnering Care Management Agencies

1. Partnering CMAs are responsible for tracking and monitoring completion of requirements for HARP-enrolled Members to ensure that at least 75% compliance is maintained for each of the following areas:
    a. Within 30 days of Health Home Enrollment or subsequent designation as HARP-enrolled:
        i. Completion of HCBS Eligibility Assessment (or documentation of declining assessment)
            a) $\frac{\text{\# Members who completed the Assessment}}{\text{(Total HARP-enrolled Members – those who declined Assessment)}}$
    b. Within 90 days of Health Home Enrollment or subsequent designation as HARP-enrolled:
        i. Completion and submission of HCBS Level of Service Request to MCO
            a) $\frac{\text{\# Completed LOSRs}}{\text{(Total \# Eligibility Assessments Completed – (those who declined}}$

ii. Documentation of Level of Service Determinations for each requested service
   a) Completed LOSD Documentation

iii. Completion and submission of Full HCBS Plan of Care to MCO
   a) # Completed HCBS Plan of Care submitted to MCO / Total Members with Approved LOSD

iv. Engagement with HCBS Providers and Receipt of requested HCBS Services
   a) Members receiving HCBS Services / Total Completed Full Plan of Care

c. Annual completion of above requirements for Members who remain HARP-enrolled

2. Partnering Care Management Agencies who do not maintain at least 75% overall compliance with the above requirements will be required to complete the following additional procedures:
   a. Complete a Root Cause Analysis for each area of non-compliance
   b. Submit a Corrective Action Plan to Bassett CHN Lead Health Home Administration detailing how and when at least 75% compliance will be achieved
   c. Complete a Meeting to review and approve Corrective Action Plan

3. If a Partnering Care Management Agency is out of compliance in any area, Basset CHN Lead Health Home or involved MCOs may implement punitive measures which may include any of the following:
   a. Restriction of ability to be assigned additional HARP Members until compliance is achieved in all areas
   b. Reassignment to HARP-enrolled Members to other CMAs with the capacity to ensure compliance
   c. Financial penalties or increased administrative cost deductions

Related Forms & Documents:

- ◊ **DOH-5055 Health Home Patient Information Sharing Consent**
- ◊ **DOH-5230 Functional Assessment Consent**
- ◊ **DOH-5032 Authorization of Release of Health Information (Including Alcohol/Drug Treatment and Mental Health Information) and Confidential HIV/AIDS-related Information**
- ◊ **BH HCBS Eligibility Assessment**
- ◊ **BH HCBS Plan of Care**
- ◊ **Bassett CHN HARP/HCBS MCO Approval Protocol**
- ◊ **Bassett CHN HARP-HCBS Guide**
- ◊ **Bassett CHN Care Management Record Documentation Guide**

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