Bassett Healthcare Network
Community Health Navigation

Policy Title: Standards and Requirements of HARP Members and Accessing Home and Community Based Services and Community Oriented Recovery and Empowerment Services	**DOH Policy Name:** ➢ **New York State: Health and Recovery Plan (HARP) Adult Behavioral Health Home and Community Based Services (BH HCBS) Provider Manual** ➢ **Revised Adult BH HCBS Workflow Guidance for HARP and HIV SNP Members Enrolled in Health Home** **DOH Reference Number: N/A** **Effective Date:** ➢ **09/26/2022** ➢ **January 2022**
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POLICY STATEMENT

Bassett Community Health Navigation Health Home (BCHNHH) and Partnering Care Management Agencies (CMAs) will ensure any enrolled member who is found eligible for the Health and Recovery Program (HARP) is provided information regarding the services available through this insurance designation. Care Managers (CMs) must assure members understand the benefits of HARP, and if they desire, assist members with enrolling in HARP and for those already approved for HARP, assist with seeking and enrolling in Home and Community Based Services (HCBS). It is also the policy of BCHNHH that only members interested in Adult HCBS will need to receive the NYS Eligibility Assessment.

BCHNHH intends to provide services that promote significant improvements in the Behavioral Health System as we move into a recovery-based Managed Care delivery model. Our CMA network will provide services that emphasize and support a person's potential for recovery by optimizing quality of life and reducing symptoms of mental illness and substance use disorders through empowerment, choice, treatment, educational, employment, housing, and health and well-being goals as outlined in this policy.

SCOPE

This policy is intended to create a supportive and empowering environment for people with behavioral health conditions to live productive lives within our communities utilizing services such as HCBS/CORE which are offered through the HARP insurance plans.

BCHNHH shall develop, disseminate, and review at least annually this policy that addresses purpose, scope, roles and responsibilities, management commitment, coordination and collaboration between entities, and compliance.

OBJECTIVES

BCHNHH provides this policy as guidance in determining HARP eligibility and enrollment, requirements of the HCBS Eligibility Assessment and accessing HCBS and CORE services. The Behavioral Health Home and Community Based Services (BH HCBS) provide opportunities for adult Medicaid beneficiaries with mental illness and/or substance use disorders to receive services in their own home or community. This process will be person-centered and support needs in a manner that reflects individual preferences and goals, and will require an annual assessment of service eligibility and needs of each member.

DEFINITIONS

Health and Recovery Plan (HARP)

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.

Home and Community Based Services (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.

1. Habilitation Services
2. Education Support Services
3. Non-medical Transportation
4. Pre-vocational Services
5. Transitional Employment
6. Intensive Supported Employment
7. On-going Supported Employment

Community Oriented Recovery and Empowerment (CORE)

Available for people 21 and over who are enrolled in a Medicaid Managed Care Health and Recovery Plan (HARP) or HIV Special Needs PLAN (SNP) with RE Codes H1 or H4. Also required is recommendation by a Licensed Practitioner of the Healing Arts (LPHA).

1. Community Psychiatric Support and Treatment
2. Family Support and Training
3. Psychosocial Rehabilitation
4. Empowerment Services-Peer Support

Person-Centered Care

Services should reflect an individual's goals and emphasize shared decision-making approaches that empower members, provide choice, and minimize stigma. Services should be designed to optimally treat illness and emphasize wellness and attention to the persons overall well-being and full community inclusion.

ROLES AND RESPONSIBILITIES

Health Home Administration Responsibilities

It is the responsibility of the BCHNHH to ensure that all staff are trained to identify and review what makes a member HARP/HCBS/CORE eligible and knowledgeable on what services are provided by providing a training and an attestation form to each staff.

CMA Supervisor Responsibilities

Ensure Qualified Care Managers are completing Eligibility Assessments for the HARP enrolled members seeking HCBS/CORE services.

Care Manager Responsibilities

It is the responsibility of the CM to obtain information to determine a member's eligibility and appropriateness for services needed, complete annual and as needed assessments, as well as ensuring member is aware of additional resources such as HCBS services.

PROCEDURES

HARP Eligibility & Enrollment

Medicaid beneficiaries age 21 and older with SMI and/or SUDs are eligible to enroll in a HARP with their Managed Care Plan (MCO).

1. 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.

2. Care Manager will check e-PACES and verify the Medicaid case has been assigned an "H9" code.
    a. If the case does not have an H9 code, the individual is not eligible to enroll in a HARP, at this time.
    b. If the Medicaid case has an "H9" code, the individual should contact New York Medicaid Choice to elect HARP enrollment.

3. The CM should assist the individual in contacting New York Medicaid Choice at 1-855-789-4277; TTY users: 1-888-329-1541. The individual must be present on the call and specifically request New York Medicaid Choice to enroll the member in a HARP.
    a. 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. The following member information is needed when contacting New York Medicaid Choice:
        i. Medicaid Client Identification number (CIN) or social security number (SSN)
        ii. Full name
        iii. Date of birth
        iv. Home address and telephone number, if available.

4. HARP eligibility and enrollment status is indicated by the restriction/exception codes that begin with the letter “H”.

HARP H Codes and Descriptions	
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

5. Individuals identified as HARP eligible or enrolled must be informed by the care manager of 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.
    a. CM will describe the assessments completed prior to engagement in HCBS, explain the enrollment process, and identify the roles of the Care Manager, HCBS Provider, and the MCO within the enrollment process

6. Individuals enrolled in HIV SNPs determined by the State to be HARP-eligible may also be eligible for BH HCBS.

7. Members who show an H9 code 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 Care Managers can assist eligible individuals may contact New York Medicaid Choice to learn about available enrollment options.

Reasons a HARP Eligible Individual May Not Show an H Code

1. HARP enrollment may be pending and will become effective at a future date.

2. The individual previously chose not to enroll in a HARP, otherwise known as “opting-out” of HARP enrollment.

3. The individual’s address has not been updated with Medicaid, causing HARP enrollment notices sent by New York Medicaid Choice to be returned.

4. 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.

5. 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.

6. The member is enrolled in both Medicaid and Medicare a.k.a. “dual eligible”

CORE Workflow and Services

CORE Eligibility

Eligibility for CORE services is based on three criteria:

1. The individual must be HARP eligible
2. The individual must be enrolled in a HARP or HIV-Special Needs Plan (SNP); and
3. The services must be recommended by a Licensed Practitioner of the Healing Arts (LPHA)
    a. An "LPHA" is a qualified licensed professional who can recommend CORE services based on their clinical expertise and scope of practice
    b. The LPHA recommendation determines medical necessity of the CORE services identified for the individual

LPHA Clinical Discretion Recommendation

1. There are no standardized assessment criteria by which the LPHA will make their determination an individual would benefit from CORE Standard LPHA recommendation form:
    a. https://omh.ny.gov/omhweb/bho/core/lpha-memo-and-recommendationform.pdf
2. If the referral source cannot provide an LPHA Recommendation Form, they should still go ahead and make a referral
3. A single LPHA recommendation may be used for one or multiple CORE services

LPHA Qualifications

1. Nurse Practitioner
2. Physician
3. Physician Assistant
4. Psychiatric Nurse Practitioner
5. Psychiatrist
6. Psychologist
7. Registered Professional Nurse
8. Licensed Mental Health Counselor
9. Licensed Creative Arts Therapist
10. Licensed Marriage & Family Therapist
11. Licensed Psychoanalyst
12. Licensed Clinical Social Worker
13. Licensed Master Social Worker, under the supervision of an LCSW, licensed psychologist, or

psychiatrist employed by the agency

CORE Referral

Referrals to CORE look like referrals made to most other services:

1. Identify the CORE Service type to support the individual's needs/goals
2. Identify the CORE provider
3. Contact CORE provider(s) to make the referral
4. Referral processes may look different between different providers
5. Coordinate for LPHA recommendation, if necessary
6. Communication and collaboration between referral sources and CORE providers are key to support the individual's engagement in services Making a Referral to CORE Services

Best Practice: Many providers have found that a warm hand-off supports engagement. Whenever possible, the referral source should support the individual by attending a meeting or call early in the process to share information and help build rapport.

CORE Referral vs. LPHA Recommendation

Referral

1. Can be made by anyone, including the individual
2. Is the process of connecting or linking an individual to CORE Services
3. The process may be a little different for every provider, just like clinics set their own referral and intake processes

LPHA Recommendation

1. May only be done by a qualified LPHA (licensed staff within their scope of practice)
2. Is a standardized form that documents medical necessity
3. Is completed before or during the Intake and Evaluation process for CORE

CM Qualifications for NYS Eligibility Assessment for Adult BH HCBS:

The State remains committed to ensure that the high need behavioral health population shall be served by staff who meet the appropriate education and experience.

Education

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

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, educational, legal, housing and financial services).

Supervision

Supervision from a:

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

Training

Completion of:

1. Specific training on the array of services and supports available, person-centered care planning process, and assessment of individuals whose condition may trigger a need for HCBS and supports; and
2. Mandated training on the New York State Eligibility Assessment instrument; and
3. Additional training as required by the State.

For further information regarding qualifications refer to: *BCHN007 Standards and Requirements of HH+ Member Service Provision Policy*

Waiver of NYS Eligibility Assessor Qualifications for Adult BH HCBS

Effective September 1, 2019, care managers and supervisors may request a waiver of staff qualifications to administer NYS Eligibility Assessments for Adult BH HCBS.

Please submit all waiver requests online here: Waiver of NYS Eligibility Assessor qualifications for Adult BH HCBS and HH+ SMI.

Important: Waiver approval alone does not authorize an agency to provide/bill for HH+ services or NYS Adult BH HCBS Eligibility Assessments; all other applicable requirements (e.g., HH+ Attestation, RCA contract) authorizing your agency for such still apply. For Adult BH HCBS Assessors, all currently mandated UAS-NY Assessor trainings are still required and cannot be waived. HH CMAs/RCAs who receive waiver approvals are responsible for notifying their Health Home(s) and/or MCO(s) accordingly.

Eligibility Assessment

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 CM should help the individual make an informed choice about which available services best addresses their health needs and goals.

HARP members who are interested in BH HCBS will be individually assessed for BH HCBS eligibility using the NYS Eligibility Assessment (EA), and if eligible, eligibility is determined for Tier 1 or Tier 2 services.

Tier 1 – Education support services or individualized employment support services
Tier 2 – All of Tier 1, plus habilitation

The HCBS Eligibility Assessment can be completed with the member face-to-face or met via telehealth with the member.

1. The CM 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).
    a. The CM should discuss services and determine if the member is interested in the additional support and document the discussion.
    b. The CM may complete the HCBS Eligibility Assessment during intake or at another time.
    c. The CM must document in the members Care Management Record:
        i. Discussion of HCBS and a members decision to proceed with services
            1. If the member declines services the CM must:
                a. Denials must be documented in the Plan of Care.
                b. Upload the HCBS Denial Form to the Documents Section.
                c. Complete a Note outlining the conversation with the member and reason for the denial.
            2. If the member agrees to services a CM must:
                a. Complete the EA
                b. Complete a note outlining the completion of the EA.
                c. Update the Plan of Care to include management of HCBS.
                d. Upload the EA to the documents section.
                    i. EA must be completed within 90 days of enrollment or documentation of denial must be uploaded and noted.

If a member would like to receive an HCBS service that is not available in their geographic region, the CM should contract BCHNHH to alert the members MCO of the gap in services.

2. There are circumstances that will result in the individual not pursuing HCBS after completing the NYS Eligibility Assessment. In these scenarios, the CM 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 CM on the completion of required Health Home assessments, plans of care, and referrals to other service providers. Scenarios include:
    a. Individual is found not eligible for HCBS based on the NYS Eligibility Assessment results.
    b. Individual is found eligible for HCBS but does not feel HCBS will help them reach their identified life role goal.
    c. Individual is found eligible for HCBS but chooses to remain in a State Plan service already meeting their need(s).
    d. 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, CM will document this within the UAS assessment platform, as well as in the member's Plan of Care.

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.

Level of Service Determination for HCBS/CORE

After the CM completes the NYS Eligibility Assessment and determines that the individual is eligible for and interested in a referral to HCBS, the CM submits a HCBS Level of Service Determination request to the member's MCO. Please refer to MCO contact list. This request may be made in a written or verbal format, as agreed to by the MCO and the CMA. 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.

1. The MCO will work with the CM toward resolution of any issues impeding approval of the Level of Service request.
2. 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.

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.

1. 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 CM. 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).

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 CM shall ensure that when assisting the individual in choosing a HCBS provider(s), that this is done using a conflict-free approach.

Referrals to HCBS

Upon receipt of the MCO's LOSD approval:

1. The CM should ensure referrals are made in a timely fashion after the LOSD is approved and should work to keep the member engaged, ensuring linkage to services.
    a. This may include sending reminders for appointments, contacting the member and/or providers throughout the referral/intake process, and offering transportation, as needed.
2. With proper consent, the CM makes a referral for HCBS to the individual's choice of provider(s).
    a. The CM 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).
        i. 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 and Evaluation by HCBS/CORE Provider

Upon receiving the referral from the CM:

1. Each HCBS provider shall notify and provide the MCO with the date of their initial scheduled intake/evaluation appointment with the individual.
    a. If this initial date changes, the HCBS provider must notify the MCO.
    b. 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.

Authorization of Ongoing HCBS/CORE

After the HCBS/CORE provider completes the intake/evaluation (or the first 3 visits, whichever comes first), to request MCO authorization to provide ongoing HCBS, the HCBS/CORE provider must submit:

1. The Prior and/or Continuing Authorization Request Form with recommended frequency, scope and duration to the MCO.
2. The MCO will review the documentation provided and issue a determination within authorization request time frames described in the Medicaid Managed Care Model Contract.
    a. The MCO must inform the CM, HCBS provider, and the member of the determination.
        i. 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.
3. Once the HCBS provider has received authorization for scope, duration and frequency of HCBS, the HCBS provider must notify the CM to add these service elements to the individual's Plan of Care.

HCBS Plan of Care Submission to the MCO

As the single point of contact the CM maintains the members Plan of Care, which is driven by the individual's life and recovery goal(s), which are supported by HCBS, behavioral health, medical, community and social supports 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 CM shall work with family, social supports, 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 CM, the HCBS provider and the MCO.

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 CM as part of the standard Health Home comprehensive assessment process (refer to *Federal Adult Behavioral Health HCBS Plan of Care Documentation Requirements* for the required elements). The individual must sign the POC prior to submitting the completed POC to the MCO.

1. The CM 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.
    a. 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.
2. After all required elements are added to the Plan of Care, the CM will submit the POC to the MCO.
3. 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.
4. The MCO will work with the CM 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.
5. If the Plan of Care is updated to reflect changes in HCBS, the revised Plan of Care should be shared with the MCO.

Ongoing Maintenance of the Plan of Care

The CM is responsible for engaging all providers included in the individual's POC to support a truly integrated, and coordinated plan. The POC shall be updated to reflect changes in the individual's needs, goals, HCBS eligibility, and/or service needs. The NYS Eligibility Assessment is valid for the period of one year from the date of completion. Therefore, re-assessment for BH HCBS eligibility will be conducted on an

annual basis, and/or after a significant change in the member's condition warrants a change to be made to the members POC.

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.

COMMUNICATION/TRAINING/IMPLEMENTATION

The Health Home will be responsible for providing necessary training needed to follow procedures as outlined in this policy. The HH will distribute to CMAs to be reviewed and track attestation forms upon implementation. The HH will review annually to ensure trainings are up-to-date and maintained.

QUALITY MANAGEMENT & PERFORMANCE IMPROVEMENT

BCHNHH and Partnering Care Management Agencies will review a selection of member cases each month to ensure those identified as eligible for HARP are being told by their CM and a discussion is present in the members care management record clearly identifying the services they are eligible for and the members choice to continue with the eligibility assessment or decline.

RELATED FORMS

- *NYS Health and Recovery Plan Adult Behavioral Health Home and Community Based Services Provider Manual*
- *NYS Health and Recovery Plan (HARP)/Mainstream Behavioral Health Billing and Coding Manual*
- *Waiver of NYS Eligibility Assessor qualifications for Adult BH HCBS and HH+ SMI*