

## **POLICY: 1.012 HEALTH AND RECOVERY PLANS (HARP)/HOME AND COMMUNITY BASED SERVICES (HCBS)**

Eligibility for Home and Community Based Services (HCBS) through the Health and Recovery Plan (HARP) must be confirmed *no later than 21 days* after a patient has been enrolled into the Health Home (HH) program. Following NYS Department of Health’s recommendation for an “expedited workflow,” Plan of Care (POC) must be created in conjunction with the patient’s screening for HCBS eligibility. POCs must be created face-to-face and be person-centered, which means that patients should have an active role in developing their POC alongside their assigned Care Manager (CM). The patient’s continued eligibility for HCBS must be confirmed at least every year and when the patient has a significant change in their health status; the patient’s POC must be updated accordingly.

### **What are HARP and HCBS?**

The Health and Recovery Plan (HARP) is a health plan for Medicaid patients with select Serious Mental Illness (SMI) and Substance Use Disorder (SUD) diagnoses that also have significant behavioral health issues. Patients enrolled in HARP receive Home and Community Based Services (HCBS), a waiver program which allows HARP patients to receive services in their home or community.

Patients eligible for Health Home services and HARP have been determined to need more intensive substance use and behavioral health services beyond what the HH program provides. The New York State Department of Health (NYSDOH) may determine patient’s eligibility for HARP and automatically enroll them into HARP (i.e., HARP Enrolled) prior to the patient’s enrollment into HH by the CMA. Other patients may be eligible for HARP, but not yet enrolled (i.e., HARP Eligible), in which case they would first be enrolled into HH services.

### **PROCEDURES:**

#### **HARP/HCBS**

1. Patients are HARP eligible/HARP enrolled patients through ePaces and MAPP. ePaces identifies these patients by specifying a H1-H9 restriction exception (RE) code. MAPP provides a HARP column that indicates whether the patient is HARP enrolled, HARP eligible or not eligible for HARP.
  - a. The following table displays a breakdown of HARP RE rate codes:

| <b>RE Code</b> | <b>RE Code</b>                      |
|----------------|-------------------------------------|
| H1             | HARP ENROLLED W/O HCBS              |
| H2             | HARP ENROLLED WITH TIER 1 HCBS      |
| H3             | HARP ENROLLED WITH TIER 2 HCBS      |
| H4             | SNP HARP ELIG W/O HCBS              |
| H5             | SNP HARP ELIG With HCBS TIER 1 HCBS |

|    |  |
|----|--|
| H6 | SNP HARP ELIG With HCBS TIER 2<br>HCBS |
| H9 | HARP ELIG PENDING ENROLLMNT            |

- b. For bottom up referrals, NYP Health Home uses ePaces, MAPP and Managed Care Organization (MCO) data to determine eligibility status.
  - c. HARP eligibility for top down patients has been confirmed before assignments have been finalized through BTQ.
2. The process of consent for enrollment into HH services for HARP eligible/HARP enrolled patients should follow the Enrollment Policy and Procedures in this manual. The Consent Form must specify to which Managed Care Organization (MCO) the patient belongs.
3. As a best practice, the CMA will confirm the patient’s eligibility to receive Home and Community Based Services (HCBS) services through HARP by completing the NYS Eligibility Assessment (brief interRAI) *within 30 days* of the patient’s enrollment in HH; completion of the brief, however, must *not exceed more than 90 days* after the patient has been enrolled in HH services.
  - a. As a best practice, the CMA will complete the NYS Eligibility Assessment (brief interRAI) *within 10 days, but no later than 21 days* after the patient has been assigned to the CMA. This assessment determines the type of HARP services for which patient is eligible (i.e., Tier I or Tier II).
  - b. CMs conducting assessments with HARP patients must meet all educational and experience requirements, and be supervised and trained as outlined by the NYSDOH (see *Appendix H*).
4. In accordance with the NYSDOH’s recommendation for an “expedited workflow,” the CMA should start generating the Plan of Care (POC) in conjunction with the NYS Eligibility Assessment (brief interRAI). The POC must be thoroughly completed in conjunction with the comprehensive assessment. Please see *Appendix I* for an overview of the “expedited workflow” for HCBS eligibility screening, and completion and approval of the POC.
  - a. The POC must be person-centered. Person-centered planning requires close collaboration between the patient and his/her assigned CM (CM) and should aim to strengthen the patient’s voice, build the patient’s resiliency and foster the patient’s recovery.
  - b. The POC must be generated in a language that is understandable to the patient.
  - c. The CM must provide the patient a comprehensive overview of the services, supports and resources available to the patient in This process may require the CM to (a) assess the patient’s knowledge of their health condition and treatment options and/or provide pertinent fact sheets, (b) use language that is appropriate and understandable, (c) provide visual aids as necessary, (d) offer copies of brochures for provider services and community resources, and/or (e) suggest sharing this information with their family and other supports.
  - d. The POC for HARP patients must adhere to the requirements detailed in the *Care Plan* policy in this manual and also include the following information:
    - i. Type of HCBS for which the patient is eligible (e.g., Not Eligible, Eligible for Tier I HCBS only, Eligible for Tier 1 and Tier 2 HCBS);
    - ii. Summary of the NYS Community Mental Health Assessment portion of the NYS Eligibility Assessment (brief interRAI);
    - iii. Specific recommendation of HCBS that are tailored to the individual’s goals, preferences and needs;
    - iv. Specific risk factors and action steps to minimize them; and

- v. Affirmation that the patient voluntarily chooses to live in their current residence
  - e. CMs must print a copy of the POC, and have patients sign it to confirm agreement with the POC. Once the patient has signed the POC, the Care Management Agency must send to the MCO as directed in Appendix I. If the CM has issues with communication with the MCO, they may contact the NYPHH to assist in communication.
  - f. Once the POC is approved by the MCO, a copy can be shared with the patient, the patient's medical and behavioral health and social service providers, the patient's family and other supports, as necessary.
  - g. The MCO will provide a Level of Service Determination to the CMA within 3 business days of the POC being approved.
  - h. The CM works with the patient and MCO to identify HCBS providers needed for the patient to meet their goals.
    - i. CMs will work with the MCO as prescribed in the guidance in Appendix I. It is the CM's responsibility to understand the MCO's requirements for HCBS. If at any time there is an issue, the CM should contact their supervisor and / or the NYPHH for further guidance.
    - ii. The CM will coordinate with the identified HCBS providers to ensure referrals and intakes are completed. CM must ensure all HCBS providers are documented on the DOH 5055
  - i. As a part of Health Home Care Coordination, the CM will monitor the patient's progress on the POC monthly.
  - j. The MCO approved POC must be scanned and uploaded into ACD by the CM.
  - k.
5. At a minimum, assigned CM's must reassess patients to confirm continued HCBS eligibility annually or when the patient has a significant change in their health status (e.g., hospitalization, loss of housing) and update the patient's POC accordingly. Any update to the POC must be sent to the MCO and NYPHH.
  6. Payments for core services provided to HARP/HCBS patients will be determined based on completion of the brief interRAI and comprehensive assessments.
    - a. Assessments must be completed thoroughly and accurately to determine proper payment.
    - b. Payments will be sent to NYPHH and NYPHH will disburse them to the CMAs.

### **Documentation**

1. The HH Consent Form must specify the MCO to which the patient belongs.
2. The POC for HARP patients should be completed using the State's mandated template and also through the *Care Plan* function on ACD.
3. POCs are to be emailed to appropriate MCO and NYPHH.

## APPENDIX H. NYS Requirements for the Education, Experience, Supervision and Training Requirements of CMs Conducting HCBS Eligibility Assessments with HARP Patients<sup>1</sup>

### ➤ Education

1. A bachelor's degree in one of the fields listed below<sup>2</sup>; or
2. NYS licensure and current registration as a Registered Nurse and a bachelor's degree; or
3. A Bachelor's level education or higher in any field with five years of experience working directly with persons with behavioral health diagnoses; or
4. A Credentialed Alcoholism and Substance Abuse Counselor (CASAC)

### ➤ Experience

1. Two years of experience:
  - a. In providing direct services to people with Serious Mental Illness, developmental disabilities, or substance use disorders; or
  - b. In linking individuals with Serious Mental Illness, developmental disabilities, or substance use disorders 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).  
\*\*A master's degree in one of the qualifying education fields may be substituted for one year of Experience.

### ➤ Supervision must be provided by a:

1. Licensed level healthcare professional (e.g., RN, licensed clinician, psychologist) with prior experience in a behavioral health clinic or care management supervisory capacity;  
OR
2. Master's level professional with 3 years prior experience supervising clinicians and/or CMs who are providing direct services to individuals with SMI/serious SUDs.

### ➤ Training

1. Specific training for the designated assessment tool(s), the array of services and supports available, and the patient-centered service planning process. Training in assessment of

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<sup>1</sup> Discontinuation of Waiver Applications and Change in Qualifications for Care Managers Conducting the NYS Community Mental Health Health Assessment (CMHA). Accessed 28 April 2017, [https://www.health.ny.gov/health\\_care/medicaid/program/medicaid\\_health\\_homes/docs/cm\\_ha\\_memo\\_qual.pdf](https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/cm_ha_memo_qual.pdf)

<sup>2</sup> Qualifying education includes degrees featuring a major or concentration in child and family studies, community mental health, counseling, education, nursing, occupational therapy, physical therapy, psychology, recreation or recreation therapy, rehabilitation, social work, sociology, or speech and hearing.

individuals whose condition may trigger a need for specific HCBS services and supports, and an ongoing knowledge of current best practices to improve health and quality of life.

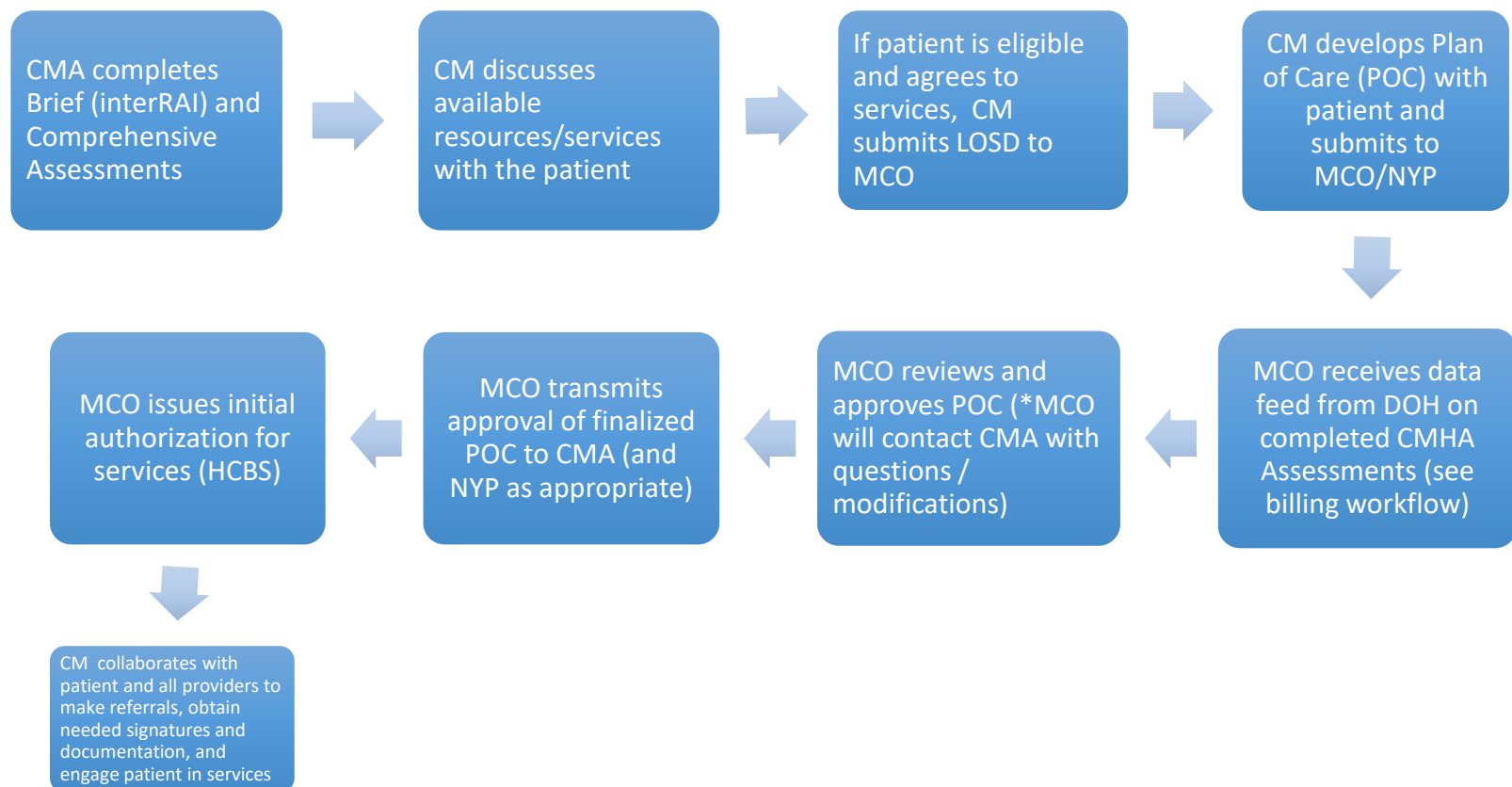
2. Mandated training on the New York State Community Mental Health Assessment instrument and additional required training.

- a. Review

[https://www.health.ny.gov/health\\_care/medicaid/program/medicaid\\_health\\_homes/docs/uas\\_support\\_for\\_users.pdf](https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/uas_support_for_users.pdf) for more information and training requirements.

## APPENDIX I. Expedited Plan of Care Workflow

The state has established guidelines for an expedited Plan of Care workflow whereby the CMA can conduct the Brief Assessment and immediately proceed to completing the Plan of Care with HARP patients. For more information, please visit [https://www.health.ny.gov/health\\_care/medicaid/program/medicaid\\_health\\_homes/docs/workflow\\_visual.pdf](https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/workflow_visual.pdf).



- ❖ The Brief (interRAI) must be completed *no later than 21 days* after the patient has been assigned to the CMA by NYP.
- ❖ While the Brief interRAI and Plan of Care may be completed simultaneously by the CMA, the Comprehensive Assessment must still be completed *no later than 90 days* after the patient has been enrolled to receive HH services.
- ❖ The CMA and MCO will communicate to discuss NYS Eligibility Assessment & Plan of Care development (as needed)