Appendix XIX — Health and Recovery Plan (HARP)

I. Recovery-Oriented Principles

Roles and responsibilities relating to recovery-oriented principles are covered in the main provider manual, Section 9.1.

II. Non-Urgent Care

Policies and procedures regarding unscheduled or non-urgent care are covered in the main provider manual, Section 3.4.

III. Behavioral Health Home and Community-Based Services (BH-HCBS)

Within the HARP, access to an enhanced benefit package will be offered in addition to all Medicaid behavioral health and physical health benefits. The enhanced benefit package of Home and Community-Based Services (HCBS) is designed to assist enrollees in their recovery and continued tenure in the community. In order to receive HCBS, members must receive an initial assessment, with follow-up assessments done annually. Individuals enrolled in HARP will receive an assessment for HCBS eligibility using a tool derived from the interRAI Community Mental Health assessment designed for New York. The HCBS eligibility assessment will be conducted to determine if HARP enrollees appear eligible for HCBS. Where such eligibility potential is determined, the full Community Mental Health assessment will be administered to assist in the development of a strengths-based, person-centered care plan.

Required Steps for HCBS Eligibility Assessment and Authorization

It is anticipated that all individuals enrolled in a HARP will receive Care Management from a Health Home or another State-designated organization that have been identified by the HARP to provide care management. Additionally, the entity providing the care management services will conduct the functional assessment to determine eligibility for HCBS and to assist in developing plans of care which will include recommended HCBS. Entities providing care management will use the Health Commerce System (HCS) to access the assessment tools.

Guidelines listed in the NYS HCBS Provider Manual (latest version available at https://www.omh.ny.gov/omhweb/guidance/hcbs/html/services-application/) outline how HCBS care planning and utilization management activities shall emphasize attention to member strengths, goals, and preferences and ensure member choice of service options and providers.

Care Plan Requirements

Members in the HARP will have a needs-based, person-centered, integrated, recovery-oriented plan of care. The plan of care will be developed by the Health Home or other State-designated organizations that have been identified by the HARP to provide care management, informed by the member and their family, and in collaboration with the care team.

Based on a conflict-free independent assessment of functioning, the HCBS portion of the plan of care will meet the following requirements:

- The plan of care will include services chosen by the individual to support independent community living in the setting of his or her own choice and must support integration in the community, including opportunities to seek employment, to engage in community life, to control personal resources, and to receive services within the community;
- Include the individual's strengths and weaknesses;
- Be developed to include clinical and support needs that are indicated by the independent functional

assessment;

Comprise goals and desired outcomes chosen by the individual;

Include Medicaid and non-Medicaid services and supports (natural supports and other community resources) that will enable the individual to meet the goals and outcomes identified in their service plan;

Identification of risk factors and barriers with strategies to overcome them;

Be reviewed and approved by member and their family/support persons, as appropriate;

Include the individual and the entity that is responsible for the implementation and oversight of the plan of care, review of progress, and need for modifications if desired outcomes are not being met or the individual's needs change;

Include an informed consent of the individual in writing, along with signatures of all individuals responsible for the plan implementation;

Be sent to all the individuals and others involved in implementing and monitoring the plan of care; and

The plan should not include services that are duplicative, unnecessary or inappropriate.

IV. Appointment Availability Standards for BH-HCBS

Healthfirst will follow the required appointment and availability standards for access for the following HCBS:

For Short-Term and Intensive Crisis Respite services, access will be provided within 24 (twenty-four) hours of the request

For Psychosocial Rehabilitation, Community Psychiatric Support and Treatment, Habilitation Services, Family Support and Training services will be provided within two (2) weeks of request (unless appointment is response to an emergency or hospital discharge or release from incarceration, in which case the standard is five [5] days of the request)

Educational and Employment Support Services will be provided within two (2) weeks of the request

Peer Support Services (PSS) will be provided within one (1) week of request (unless appointment is pursuant to an emergency of hospital discharge, in which case the standard is five [5] days, or if PSS are urgently needed for symptom management, in which case the standard for access is 24 [twenty-four] hours)

V. Credentialing Criteria for Designated BH-HCBS Providers

Healthfirst credentialing criteria for designated HCBS providers is as follows, and is subject to final HCBS credentialing issues:

Healthfirst will accept State-issued HCBS designation, in place of Healthfirst's credentialing process, for HCBS providers and any individual employees, subcontractors, or agents

Healthfirst will collect and accept program integrity–related information as part of the licensing and certification process

Healthfirst requires that HCBS providers not employ or contract with any employee, subcontractor, or agent who has been debarred or suspended by the federal or state government, or otherwise excluded from participation in the Medicare or Medicaid program

VI. Description of Referral Process for HCBS

The Home and Community-Based Services (HCBS) are available to HARP eligible members who are enrolled in Healthfirst's HARP plan and in a Health Home (HH).

The process is as follows:

The HH Care Manager will conduct the HCBS eligibility assessment with the member. If eligible, the HH Care Manager will conduct the full HCBS assessment, the NYS Community Mental Health Assessment to help determine the full array of recommended HCBS

In collaboration with the member, and in consultation with providers as necessary, HH Care Manager develops a fully integrated Plan of Care (POC) that includes physical and behavioral health services and recommended HCBS, including the scope, duration, and frequency of HCBS, and selected in-network providers. Member must be given a choice of at least two HCBS providers from Healthfirst's network, and there must be documentation in the POC that choice was given to the member

HH Care Manager forwards the fully integrated POC to Healthfirst for review and approval. Healthfirst care managers will work collaboratively with the HH Care Manager and member to finalize an approved POC

The HH Care Manager ensures the member is referred for the services listed in the POC

After assessment by the HCBS providers, the service plan will be forwarded by the HCBS provider to Healthfirst for authorization

The HH Care Manager monitors the POC; ensures that the member is getting HCBS reflected in the POC; and revises the POC when necessary, incorporating member input and choice. When the POC is revised, the Healthfirst care manager will review and communicate back to the HH Care Manager.

VII. HCBS Utilization Monitoring

Please reference the Provider Contract Exhibit 1.5 and the main Provider Manual Sections 3.2 and 3.7 for requirements for monitoring HCBS utilization for each enrollee.

VIII. Utilization Management

Healthfirst views utilization management as an opportunity to review cases and engage in collegial clinical discussions. In the review, HF care manager (CM) will focus on the assessment, diagnosis, and treatment plan. The plan is expected to delineate clear goals and state how the plan of care will lead to movement toward those goals.

In addition, the HF CM will review the assessments by HCBS providers and recommended plan to address deficits. The overall plan of care is initially approved in discussion between Health Home (HH) CM and the HF physical health (PH) and behavioral health (BH) CMs. Once the global plan of care is approved, specifics of the plan for PH, BH, and HCBS will be developed, reviewed, and approved.

As described elsewhere in the BH supplement, the care plan development is done with the full involvement of the member and, as appropriate, his/her support system. The plan should not only meet the needs based on strengths and deficits but should also be culturally sensitive. It is expected that the member has consented to the plan submitted for approval.

The goal is to provide appropriate resources to support the member and sustain him/her in the community, reducing ED visits and re-admissions to acute care while facilitating access to essential person-centered, integrated, health and recovery-oriented services in the community.

BH and PH clinical staff collaborate with the member's Health Home, as appropriate, to ensure an integrated and consistent approach for members with co-occurring physical and behavioral health conditions. The care manager ensures that all community supports, including appropriate housing, are considered and in place whenever possible, before discharge and that all relevant providers are aware of the goals and interventions described in the member's care plan to the extent necessary to facilitate communication, interface, and collaboration among clinical providers and community care/services and support.

IX. Maintenance of Member Records

Healthfirst will monitor HCBS provider adherence to established practice guidelines. All providers rendering

HCBS to our members are required to maintain a member health record in accordance with standards adopted by Healthfirst and in compliance with CMS and NCQA Guidelines for record review.

Healthfirst also strongly recommends that HCBS providers comply with professional standards and take steps to safeguard confidentiality when sharing medical-record information with other providers.

Healthfirst periodically requests medical records to conduct reviews to evaluate practice patterns, to identify opportunities for improvement, and to ensure compliance with quality standards. All Healthfirst medical-record reviews are conducted by clinical professionals, and all information contained in the records is kept strictly confidential. Healthfirst requires contracted HCBS providers to make medical records available upon request by Healthfirst.

Medical records are reviewed as part of the following activities:

- Investigating clinical quality of care
- Monitoring utilization to identify underuse and overuse of services, timely receipt of preventive and medically necessary services, and to determine root causes for potential action
- Monitoring for accuracy and completeness of coding
- Validating claims
- Monitoring for compliance with approved Clinical Practice Guidelines and Standards of Care, reporting for Quality Improvement studies
- Monitoring of HCBS provider compliance with regulatory guidelines and reporting requirements
- Monitoring for compliance with Healthfirst Medical Record Documentation Standards

The guidelines and performance indicators chosen by the clinical members of the HARP QI committee are communicated to providers through the Provider Manual, annual mailings, newsletters, and the plan's website. Performance against chosen indicators is measured annually. The Annual Evaluation also helps to drive the activities for the next year's Quality Improvement Work Plan by determining which successful interventions and actions should be continued or expanded and which actions and activities did not result in noticeable improvement and should be modified or discontinued.

The Annual Evaluation is developed by all relevant parties and is presented to the Quality Improvement Committee (QIC) and the Quality Committee (QC) for review and approval.

X. Provider Education and Training

Healthfirst Network Management will provide initial and ongoing provider education to ensure that providers and their office staff are knowledgeable about Healthfirst policies and procedures, reference documents about the needs for special-needs members and how to assist in the access of covered services to ensure that providers are fully cognizant and compliant with federal and state regulations and program standards.

Healthfirst, along with other plans, is collaborating with Managed Care Technical Assistance Center (MCTAC) on a monthly basis to create a robust online training program for providers that meets all of the training requirements for HARP. A clinical training curriculum and plan for Healthfirst Home Health, Primary Care Physicians, and Behavioral Health Providers will be made available. Additional trainings will be provided by Healthfirst's Clinical Partnership department to all Behavioral Health providers and Health Homes in collaboration with the RPC. Clinical training courses will be posted on the Provider Portal and will be available for providers at various times.

XI. HCBS Plan of Care and Utilization Review Criteria

Healthfirst Care Managers will work closely with Health Homes and providers to oversee the development and management of integrated care plans. The Health Home submits the written plan of care to Healthfirst for review no less than annually. Each plan of care will be reviewed in collaboration with the member and their

care team to ensure a person-centered, integrated, and recovery-oriented plan of care; an appropriate match of need to service; progression toward goals within expected time frames; adjustments with change in physical, behavioral, or social status; and effective use (no duplication) and coordination of Medicaid and

non-Medicaid resources. Targets that are not achieved will be evaluated for appropriateness of attainability for each individual.

Where questions arise, HF Care Managers will partner with the care team to discuss treatment and service alternatives, acting as a resource to the team to facilitate the development of an individualized plan of care that optimally utilizes network and community resources, including HCBS.

HF will utilize the HCBS criteria developed by the plans in concert with OMH. The process of HCBS review has been described in L3 B.6

XII. Billing Compliance

Please reference the MMC/FHP Contract Section 16.15 (b).

XIII. Required Documentation for Reimbursement

Please reference the MMC/FHP Contract Section 16.15 (b).

XIV. This section intentionally left blank

XV. Appeals and Grievances

Healthfirst provides an opportunity for current/potential HARP members to appeal decisions that adversely affect Home and Community-Based Waiver Services (see operating policy AG MCD-003v28).

Individuals have the right to appeal when any of the following adverse determinations occur:

HCBS are either denied, reduced, or changed

Individuals are denied the provider of their choice

For HARP and HCBS eligibility determinations, while NYS has delegated the HCBS evaluation to the HARP, only the State can make the final determination regarding denial of HCBS enrollment.

Members who require assistance with the appeal process can call the dedicated HARP Member Services at 1-855-659-5971.