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LOCAL COMMISSIONERS MEMORANDUM

Transmittal No: 19 OHIP/LCM-03

Date: May 13, 2019

Division: Office of Health Insurance Programs

To: Local District Commissioners

Subject: Health and Recovery Plans (HARP)

The purpose of this Local Commissioners Memorandum (LCM) is to inform Local Department of Social Services (LDSS) of their responsibilities for HARP enrollments and HARP Recipient Restriction/Exception (RR/E) codes.

This LCM rescinds 2018 LCM-01 *"Clarification: Health and Recovery Plan (HARP) Enrollee Renewal (recertification) on WMS".*

HARP's are now available as a plan choice on New York State of Health (NYSoH). Welfare Management System (WMS) HARP Modified Adjusted Gross Income (MAGI) eligible enrollees will begin to transition to NYSoH at renewal beginning March 2019 for authorizations through May 31, 2019.

Background

As part of the Behavioral Health (BH) transition to Medicaid Managed Care (MMC), the Department of Health (DOH) implemented a new type of special needs plan called a Health and Recovery Plan (HARP). HARP is a type of MMC plan (Plan) for Medicaid recipients 21 years of age and older, found by the State to meet certain diagnoses and service utilization related to behavioral health. HARP eligible individuals can be identified with an active HARP RR/E code in eMedNY.

For more information on the Behavioral Health Transition into Managed Care, please see the link below for the "Transition of Behavioral Health Benefit into Medicaid Managed Care and Health and Recovery Plan (HARP) Implementation" policy document.

https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/related_links/docs/bh_policy_guidance_10-1-15.pdf

Benefit Package

The HARP benefit package is identical to that of Mainstream Managed Care, with the following two exceptions:

- *Behavioral Health Home and Community Based Services are included in the HARP benefit package; and*

  Note: to receive Behavioral Health Home and Community Based Services (BH HCBS), HARP plans must provide an assessment to their HARP enrollees to identify the BH HCBS for which they are eligible to receive. The RR/E "H" codes reflect the level of services, either Tier 1 or Tier 2, for which a HARP enrollee is eligible.

- *The Long-Term Nursing Home benefit is **not** a HARP covered service.*

HARP RR/E Codes

A series of RR/E codes have been developed to identify eligibility and enrollment in a HARP.

H1 HARP Enrolled w/o BH HCBS

H2 HARP Enrolled w/Tier 1 BH HCBS

H3 HARP Enrolled w/Tier 2 BH HCBS

H4 SNP Enrolled HARP Eligible

H5 SNP Enrolled HARP Eligible w/Tier 1 BH HCBS

H6 SNP Enrolled HARP Eligible w/Tier 2 BH HCBS

H7 Opted-out of HARP Enrollment

H8 HARP Eligible – Community Referral

H9 HARP Eligible – State Identified

The Office of Mental Health (OMH) and New York Medicaid Choice (NYMC), the State's enrollment broker, are primarily responsible for data entry of the HARP RR/E codes into eMedNY, however, there will be occasions when LDSS staff are expected to update or make changes to these codes to appropriately reflect the enrollment status of a recipient.

The RR/E "H" codes are primarily used for identification purposes, however the H1-H3 codes impact premium payments made to HARPs.

Enrollment

The State's enrollment broker, NYMC, provides education, enrollment and notices for individuals identified as HARP eligible.
HIV Special Needs Plan (SNP) enrollees can remain enrolled in the HIV SNP and receive the BH HCBS waiver services that a HARP provides, if found eligible for such services upon assessment.

The LDSS is responsible for HARP enrollment and disenrollment as indicated below.

- **County to County Moves for HARP Enrollees**

  For individuals enrolled in a HARP who relocate to a different county, the LDSS is responsible for transferring the Medicaid coverage and current plan enrollment to the new county as directed in previous guidance issued by DOH - in 08 OHIP/LCM-01, "*Continued Medicaid Eligibility for Recipients Who Changed Residency (Luberto v. Danies).*"

  The LDSS in the new county is responsible for verifying that the HARP in which the individual is currently enrolled in operates in the new county. If the HARP **does operate** in the new county, LDSS staff in the new county must reenroll the individual into the same managed care plan in the new county with a start date to coincide with the start date of transferred Medicaid case in the new county of residence. The HARP provider number would be the same if available in the new county and the benefit package code for HARP enrollments is 78 for all counties.

  If the HARP in which the individual is enrolled in **does not operate** in the new county, the individual may contact the new county to select another plan or the county can outreach to the individual to select a plan to avoid a gap in enrollment. If there is only one HARP available in the new county of residence, the individual should be enrolled in that plan. If no enrollment is entered for the date that Medicaid eligibility starts in the new county of residence, the LDSS staff is responsible for disenrolling the individual to fee for service (FFS) Medicaid. The LDSS is also responsible for entering the end date for the RR/E "H" code to coincide with the disenrollment.

- **Enrollment of Newborn Children to a HARP Enrollee**

  Newborns born to HARP enrolled individuals will be enrolled in the Managed Care Organization's (MCO) mainstream MMC plan effective the first day of the month of birth unless the newborn is excluded from enrollment. For example, if the mother is enrolled in ABC HARP, the newborn will be enrolled in ABC MMC plan. This process is currently automated for Upstate cases via the State newborn process and is handled by DOH for New York City (NYC). However, if a newborn does not appear on the newborn report or the enrollment errors out, the LDSS is responsible for the MMC enrollment for the newborn effective the first of the month of date of birth.

Disenrollment

- **Long-Term Placement in a Skilled Nursing Facility**

  The HARP benefit package does not include Long-Term Nursing Home services. When the LDSS receives notification of permanent nursing home placement via submission of DOH Form LDSS-3559 *"Residential Health Care Facility Report of Medicaid Recipient Admission/Discharge/readmission/Change in Status"* or its DOH-approved local equivalent, the LDSS is responsible for disenrolling the HARP enrollee to community FFS Medicaid retroactively to the first day of the month of permanent placement. The disenrollment reason code is "93" (excluded). The LDSS is responsible for end dating the RR/E H1-H3 codes to coincide with the effective date of the disenrollment for these individuals. The LDSS should also enter the nursing home RR/E code "N9" to prevent enrollment in a managed care plan pending the nursing home eligibility determination.

- **HARP Enrollee Joins a Waiver Program- Office for People with Developmental Disabilities (OPWDD), Traumatic Brain Injury (TBI), Nursing Home Transition and Diversion (NHTD)**

  To prevent any duplication of HCBS services, HCBS waiver recipients are excluded from enrolling in a HARP. If a current HARP enrollee joins a waiver program, the individual can either contact NYMC or the LDSS to request disenrollment from the HARP. The individual can attest to either applying for a waiver program or waiver program approval. No documentation is required to leave a HARP to join a waiver.

  For a recipient that requests to disenroll from HARP and who is not yet in a waiver program, the recipient must be prospectively enrolled in the MCO's MMC plan, or another MMC plan of their choice, unless otherwise exempted or excluded from enrolling in MMC (recently in receipt of comprehensive TPHI, for example). If the individual needs more information about enrollment options, the LDSS must provide education or refer the individual to NYMC.

  For a recipient that requests to disenroll from HARP and is approved and participating in a waiver program, the disenrollment from HARP will be prospective.

  If the LDSS processes the HARP disenrollment, the LDSS must also end date any active RR/E H1-H3 codes. The end date of the RR/E H1-H3 code should coincide with the disenrollment effective date from the HARP.

- **Incarceration**

  If a HARP enrollee becomes incarcerated, the LDSS should follow the policies and procedures outlined in 08 OHIP/ADM-3 *"Maintaining Medicaid Eligibility for Incarcerated Individuals."* The LDSS must process the disenrollment from HARP retroactive to the first day of the month following the date of incarceration and end date any active RR/E "H" codes. The end date of the HARP RR/E "H" code should coincide with the effective end date of disenrollment. Disenrollment reason code is 93 (excluded) should be used for incarcerated individuals.

- **Disenrollment Due to Other Exclusions**

  If changes to Medicaid eligibility cause a HARP enrollee to become ineligible to enroll in a managed care plan, such as excess income, obtaining comprehensive Third-Party Health Insurance (TPHI), or in an Assisted Living Program facility (ALP), the LDSS is responsible for disenrolling the HARP enrollee to FFS Medicaid (including provisional coverage) and end date any active RR/E H1-H3 codes. The end date of the HARP RR/E "H" code should coincide with the effective end date of disenrollment.

  For individuals enrolled in HARP and gaining Medicare coverage, please refer to GIS 18 MA/01- *"Medicaid Managed Care Transition for enrollees Gaining Medicare"* for further details.

Any questions regarding this LCM should be directed to your local district Medicaid liaison at (518) 474-8887 for upstate counties and (212) 417-4500 for NYC. Local districts may also contact the Bureau of Program Implementation and Enrollment at (518) 473-1134 or by email at omcmail@health.ny.gov.

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