

Health Home Standards and Requirements for Health Homes, Care Management Providers and Managed Care Organizations

As of July 31, 2015

Introduction: The purpose of this guidance document is to explain and clarify the roles and responsibilities of Lead Health Homes, downstream Care Management providers and Managed Care Organizations (MCOs) for the provision of Health Home services, and for Managed Care members, the Medicaid Managed Care benefit package care management services to enrollees as required by the Medicaid Managed Care Contract.

A. State Plan Standards and Requirements for Health Homes

As specified in the State Plan, Health Homes are required to provide the following six Health Home Core Services. Health Homes must have policies and procedures in place to ensure care management services meet the following requirements.

1. Comprehensive Care Management

Lead Health Home must have planning, and policies and procedures in place to ensure care managers create, document, execute and update an individualized, person-centered plan of care for each individual.

1a. A comprehensive health assessment that identifies medical, behavioral health (mental health and substance use) and social service needs is developed.

1b. The individual's plan of care integrates the continuum of medical, behavioral health services, rehabilitative, long term care and social service needs and clearly identifies the primary care physician/nurse practitioner, specialist(s), behavioral health care provider(s), care manager and other providers directly involved in the individual's care.

1c. The individual (or their guardian) play a central and active role in the development and execution of their plan of care and should agree with the goals, interventions and time frames contained in the plan.

1d. The individual's plan of care clearly identifies primary, specialty, behavioral health and community networks and supports that address their needs.

1e. The individual's plan of care clearly identifies family members and other supports involved in the individual's care. Family and other supports are included in the plan and execution of care as requested by the individual.

1f. The individual's plan of care clearly identifies goals and timeframes for improving the individual's health and health care status and the interventions that will produce this effect.

1g. The individual's plan of care must include outreach and engagement activities that will support engaging individuals in their care and promoting continuity of care.

1h. The individual's plan of care includes periodic reassessment of the individual needs and clearly identifies the individual's progress in meeting goals and changes in the plan of care based on changes in patient's need.

2. Care Coordination and Health Promotion

2a. The Health Home provider is accountable for engaging and retaining Health Home enrollees in care; coordinating and arranging for the provision of services; supporting adherence to treatment recommendations; and monitoring and evaluating a individual's needs, including prevention, wellness, medical, specialist and behavioral health treatment, care transitions, and social and community services where appropriate through the creation of an individual plan of care.

2b. The Health Home provider will assign each individual a dedicated care manager who is responsible for overall management of the individual's plan of care. The Health Home care manager is clearly identified in the individual's record. Each individual enrolled with a Health Home will have one dedicated care manager who has overall responsibility and accountability for coordinating all aspects of the individual's care. The individual cannot be enrolled in more than one care management program funded by the Medicaid program.

2c. The Health Home provider must describe the relationship and communication between the dedicated care manager and the treating clinicians that assure that the care manager can discuss with clinicians on an as needed basis, changes in the individual's condition that may necessitate treatment change (i.e., written orders and/or prescriptions).

2d. The Health Home provider must define how care will be directed when conflicting treatment is being provided.

2e. The Health Home provider has policies, procedures and accountabilities (contractual agreements) to support effective collaborations between primary care, specialist and behavioral health providers, evidence-based referrals and follow-up and consultations that clearly define roles and responsibilities.

2f. The Health Home provider supports continuity of care and health promotion through the development of a treatment relationship with the individual and the interdisciplinary team of providers.

2g. The Health Home provider supports care coordination and facilitates collaboration through the establishment of regular case review meetings, including all members of the interdisciplinary team on a schedule determined by the Health Home provider. The Health Home provider has the option of utilizing technology conferencing tools including audio, video and /or web deployed solutions when security protocols and precautions are in place to protect PHI.

2h. The Health Home provider ensures 24 hours/seven days a week availability to a care manager to provide information and emergency consultation services.

2i. The Health Home provider will ensure the availability of priority appointments for Health Home enrollees to medical and behavioral health care services within their Health Home provider network to avoid unnecessary, inappropriate utilization of emergency room and inpatient hospital services.

2j. The Health Home provider promotes evidence based wellness and prevention by linking Health Home enrollees with resources for smoking cessation, diabetes, asthma, hypertension, self-help recovery resources, and other services based on individual needs and preferences.

2k. The Health Home provider has a system to track and share information and care needs across providers and to monitor outcomes and initiate changes in care, as necessary, to address the individual's needs.

3. Comprehensive Transitional Care

3a. The Health Home provider has a system in place with hospitals and residential/rehabilitation facilities in their network to provide the Health Home prompt notification of an individual's admission and/or discharge to/from an emergency room, inpatient, or residential/rehabilitation setting.

3b. The Health Home provider has policies and procedures in place with local practitioners, health facilities including emergency rooms, hospitals, and residential/rehabilitation settings, providers and community-based services to help ensure coordinated, safe transitions in care for individuals who require transfers in the site of care.

3c. The Health Home provider utilizes HIT as feasible to facilitate interdisciplinary collaboration among all providers, the enrollee, family, care givers, and local supports.

3d. The Health Home provider has a systematic follow-up protocol in place to assure timely access to follow-up care post discharge that includes at a minimum receipt of a summary care record from the discharging entity, medication reconciliation, timely scheduled appointments at recommended outpatient providers, care manager verification with outpatient provider that the individual attended the appointment, and a plan to outreach and re-engage the individual in care if the appointment was missed.

4. Enrollee and Family Support

4a. Enrollee's individualized plan of care reflects individual and family or caregiver preferences, education and support for self-management, self-help recovery, and other resources as appropriate.

4b. Enrollee's individualized plan of care is accessible to the individual and their families or other caregivers based on the individual's preference.

4c. The Health Home provider utilizes peer supports, support groups and self-care programs to increase enrollees' knowledge about their disease, engagement and self-management capabilities, and to improve adherence to prescribed treatment.

4d. The Health Home provider discusses advance directives with enrollees and their families or caregivers.

4e. The Health Home provider communicates and shares information with individuals and their families and other caregivers with appropriate consideration for language, literacy and cultural preferences.

4f. The Health Home provider gives the individual access to plans of care and options for accessing clinical information.

5. Referral to Community and Social Supports

5a. The Health Home provider identifies available community-based resources and actively manages appropriate referrals, access, engagement, follow-up and coordination of services.

5b. The Health Home provider has policies, procedures and accountabilities (contractual agreements) to support effective collaborations with community-based resources, which clearly define roles and responsibilities.

5c. The plan of care should include community-based and other social support services as well as healthcare services that respond to the individual's needs and preferences and contribute to achieving the individual's goals.

6. Use of Health Information Technology (HIT) to Link Services

Health Home providers will make use of available HIT and access data through the regional health information organization/qualified entities to conduct these processes as feasible, to comply with the initial standards cited in items 6a.-6d for implementation of Health Homes. In order to be approved as a Health Home provider, applicants must provide a plan to achieve the final standards cited in items 6e-6i within eighteen (18) months of program initiation.

Initial Standards

6a. Health Home provider has structured information systems, policies, procedures and practices to create, document, execute, and update a plan of care for every patient.

6b. Health Home provider has a systematic process to follow-up on tests, treatments, services and, and referrals which is incorporated into the patient's plan of care.

6c. Health Home provider has a health record system which allows the patient's health information and plan of care to be accessible to the interdisciplinary team of providers and which allows for population management and identification of gaps in care including preventive services.

6d. Health Home provider makes use of available HIT and accesses data through the regional health information organization/qualified entity to conduct these processes, as feasible.

Final Standards

6e. Health Home provider has structured interoperable health information technology systems, policies, procedures and practices to support the creation, documentation, execution, and ongoing management of a plan of care for every patient.

6f. Health Home provider uses an electronic health record system that qualifies under the Meaningful Use provisions of the HITECH Act, which allows the patient's health information and plan of care to be accessible to the interdisciplinary team of providers. If the provider does not currently have such a system, they will provide a plan for when and how they will implement it.

6g. Health Home provider will be required to comply with the current and future version of the Statewide Policy Guidance (http://health.ny.gov/technology/statewide_policy_guidance.htm) which includes common information policies, standards and technical approaches governing health information exchange.

6h. Health Home provider commits to joining regional health information networks or qualified health IT entities for data exchange and includes a commitment to share information with all providers participating in a care plan. RHIOs/QE (Qualified Entities) provides policy and technical services required for health information exchange through the Statewide Health Information Network of New York (SHIN-NY).

6i. Health Home provider supports the use of evidence based clinical decision making tools, consensus guidelines, and best practices to achieve optimal outcomes and cost avoidance.

B. Additional Health Home Standards and Requirements

In addition to the core services established above, Health Homes must have policies and procedures in place to satisfy each of the requirements below. Health Homes shall ensure compliance by their subcontracted care management providers with applicable policies and procedures or require such providers to establish additional policies and procedures to ensure compliance with these requirements.

1. Lead Health Homes must identify a single point of contact and establish communication protocols with Managed Care Organizations (MCOs).
 - a) Health Homes must use information and performance data, including outreach and enrollment data, dashboards and other data made available through Medicaid Analytic Performance Portal (MAPP), and hold periodic meetings with care managers and MCOs to evaluate and improve performance.
 - b) Health Homes should ensure care managers have access to other pertinent administrative data that may not be available in MAPP to inform real time decision making regarding outreach and engagement efforts.
 - c) The Health Home should have an identified point of contact for community referrals including (but not limited to) those from Local Government Units (LGU's), inpatient settings, forensic releases, and community providers to coordinate timely linkage to a care manager, with special consideration for individuals receiving Assisted Outpatient Treatment (AOT) and other specific populations as described in this document.
2. Health Homes must have policies and procedures in place for responding when critical events occur, including when an enrollee 1) has presented at a hospital ER/ED and was not admitted 2) is admitted to inpatient hospital or 3) when the enrollee is in crisis and presents at a location that provides additional opportunities to outreach to an enrollee. Such policies and procedures must incorporate information that will become available through MAPP referral portal and MAPP alerts.
3. Health Home care management providers must contact enrollees within 48 hours of discharge from an inpatient unit (when they are notified or become aware of the admission), or sooner if clinically indicated, to facilitate the care transition. Health Home care managers shall engage in the discharge planning process, including the review of upcoming appointment dates and times, medication reconciliation, and potential obstacles to attending follow-up visits and adhering to recommended treatment plan.
4. When Health Home care management providers are notified or become aware of an enrollee's admission to a detox facility they must attempt to make a face-to-face contact 1) during the stay of an enrollee that has been admitted to a detox facility and 2) within 24 hours of discharge from a detox facility to ensure that the enrollee is aware of follow-up appointments and to provide supports for getting to appointments.
5. As a best practice, a lead Health Home should communicate with its care management providers to assess their capacity to accept new referrals prior to sending them assignment files. Such communication will help ensure that the care management providers will be able to act promptly in their efforts to locate and enroll prospective members. As a best practice, after receipt of a referral from a

Health Home, Health Home care management providers should begin outreach immediately. As a best practice, if the Health Home sends an assignment list during the 1st to the 15th of the month, outreach should begin immediately. If Health Home sends an assignment list on the 16th of the month or later outreach can begin immediately, but may be initiated the following month to take advantage of the full month of outreach, but no later than the 5th business day of the following month. Health Homes shall require documentation from Health Home care management providers regarding any failure of the care management provider to commence outreach activities within these timeframes. Such documentation shall state the reasons for not meeting such timeframes and shall propose a corrective action plan. Health Homes shall thereafter report such deficiencies and corrective action plans to the MCO and the State.

6. Health Home care management providers must assign care managers to enrollees based upon care manager experience and defined member characteristics including, but not limited to, acuity, presence of co-occurring or co-morbid Serious Mental Illness (SMI)/Substance Use Disorder (SUD) or co-occurring medical co-morbid conditions, and patterns of acute service use.
7. Health Homes must submit plans of care, for review and approval by the enrollee's MCO as required
8. The Health Home and MCO must establish clear lines of responsibility to ensure services are not duplicated.
9. For all individuals enrolled in a Health Home, the plan of care must include the following specific elements:
 - The individual's stated **Goal(s)** related to treatment, wellness and recovery (1e);
 - The individual's **Preferences and Strengths** related to treatment, wellness and recovery goals;
 - **Functional Needs** related to treatment, wellness and recovery goals (1e);
 - **Key Community Networks and Supports**;
 - Description of planned **Care Management Interventions and Time Frames**;
 - The individual's **Signature** documenting agreement with the plan of care; and
 - Documentation of participation by all **Key Providers** in the development of the plan of care.
10. Health Homes that provide care management and direct services, must ensure that the provider providing care management is not the same as the provider providing direct care services and that these individuals are under different supervisory structures
11. Health Home care managers are restricted from assessing a person for whom they have financial interest or other existing relationship that would present conflict of interest
12. Enrollees shall be provided with a choice of providers from among all of the MCO's network providers of a particular service. Health Homes shall document the enrollee's selection in the plan of care.
13. Health Homes must submit claims to MCOs within 120 days after the date of service to be valid, however, there is nothing to preclude the MCOs and the Health Homes from agreeing to other terms which are more favorable to the Health Home.

14. Health Homes must provide access to and information regarding training opportunities that include:
 - a) Marketing Health Home care management services;
 - b) Typical care management needs of populations with multiple co-morbidities;
 - c) Evidence-based methods for increasing engagement including Motivational Interviewing, Recovery-Oriented Practices, Person-centered Planning, role and benefits of Certified Peer Specialists/Peer Advocates and Wellness Recovery Action Plans;
 - d) Outreach and engagement strategies for members who are disengaged from care or have difficulty adhering to treatment recommendations including individuals with histories of homelessness, criminal justice involvement, first-episode psychosis and transition-age youth;
 - e) The availability and range of services that would be beneficial to Health Home members (e.g., Home and Community Based Services for HARP members and Assisted Outpatient Treatment); and
 - f) Training on any State required assessment tools.
15. Health Homes must have policies and procedures in place to ensure consistent use of any State required eligibility and assessment tools to ensure high inter-rater reliability standards.
16. Health Homes shall ensure that the approved plan of care is reassessed at least annually, and more frequently when warranted by a significant change in the member's medical and/or behavioral health condition. Such reassessment shall document the member's progress in meeting his or her goals from prior plans of care and shall be documented in the member's record.
17. The plan of care should be developed by experienced and qualified individuals.
18. When an MCO elects to request assistance from the member's Health Home Care Management provider to carry out its responsibilities to provide notice of enrollee rights under Section 13.6 of the Medicaid Managed Care Contract, the MCO shall provide the member's Health Home Care Manager with information about the means employed to contact the member, including the dates of attempted contact, the outcome of the attempted contact (i.e. mail returned undeliverable, telephone service disconnected), and the address(es) and/or telephone number(s) used to contact the member, if available.
19. Health Homes shall undertake the following engagement efforts for members lost to follow-up:
 - The Health Home shall have policies and procedures to identify members who have not received a Health Home core service for a period of two (2) consecutive months;
 - The Health Home shall have policies and procedures to ensure documentation of reasonable efforts by the Health Home to find members lost to follow-up and re-engage them;
 - Upon request, the Health Home shall provide the State with documentation of Health Home's efforts to engage members in care;
 - The Health Home shall make best efforts to conduct outreach to members who are homeless to assure that services are accessible and to identify and reduce barriers to treatment.

C. Additional Health Home Standards and Requirements for Assisted Outpatient Treatment (AOT) enrollees:

1. The Health Home will assign individuals to a Health Home care management provider within two business days from the day the MCO makes an assignment to the Health Home.
2. The Health Home care management provider will begin outreach within two business days after receipt of referral from a Health Home.
3. Individuals on AOT court orders must receive Health Home Plus services. Upon enrollment:
 - a) The Health Home care management provider must inform the Health Home when the recipient has been placed on court ordered AOT or when the court order has expired or has not been renewed (information provided in MAPP can be used to satisfy this requirement);
 - b) The Health Home must inform the MCO of the member's AOT status (information provided in MAPP can be used to satisfy this requirement).
4. Health Home care management providers working with court ordered AOT individuals must adhere to all Health Home Plus AOT Guidance issued by the State including:
 - a) Provide face-to-face contact four times per month
 - b) Work with the LGU's AOT coordinator as per local policy;
 - c) Comply with the court order and all statutory reporting requirements under Kendra's Law
 - d) Have a caseload ratio no greater than 1:12 (i.e. 8.5% of a full-time Health Home care manager's available care management time if the caseload also includes non-Health Home Plus members.
 - e) Meet the minimum personnel qualification standards and complete program requirements listed in Health Home Plus guidance available at:
http://www.omh.ny.gov/omhweb/adults/health_homes/hhp-final.pdf
5. Health Home care managers must complete and submit all AOT reporting requirements to the Office of Mental Health (OMH) as required by AOT legislation and as currently reported in the OMH CAIRS (Child and Adult Integrated Reporting System).
6. Each Health Home must assure capacity to serve individuals receiving AOT. Individuals receiving AOT can be served by Care Management providers with the qualifications and experience as described above and in HH+ guidance, as well as through Assertive Community Treatment (ACT) teams.
7. OMH is considering an expansion of the eligible HH+ populations which may include OMH State Psychiatric Center discharges and forensic or Central New York (CNY) Prison and CNY State PC releases.

D. Additional Health Home Standards and Requirements Related to the Provision of Home and Community Based Services to HARP Enrollees and HARP-eligible HIV SNP Enrollees.

1. Health Home care managers will perform Home and Community Based Services (HCBS) Eligibility Assessments to determine if HARP members are eligible for Home and Community Based Services.
2. As a best practice Health Home care managers shall complete NYS Eligibility Assessment (brief interRAI) to determine HCBS eligibility within 10 days, but not longer than 21 days of an individual's assignment to the care management provider. As a best practice the entire assessment process, including both the brief and full assessment, should be completed within 30 days of the individual's enrollment in a State-designated Health Home or other State-designated entity, but in no case shall such process be completed more than 90 days after such enrollment unless such timeframe is extended by the State as necessary for a limited period to manage the large number of assessments anticipated during the initial HARP enrollment period.
3. Health Home care managers will perform HCBS reassessments at least annually and when there is a significant change in status for HARP members receiving HCBS such as hospitalization and loss of housing.
4. Health Home care managers that perform HCBS assessments or reassessments must meet the following qualifications:
 - a) Education:
 - i) A bachelor's degree in any of the following: child & family studies, community mental health, counseling, education, nursing, occupational therapy, physical therapy, psychology, recreation, recreational therapy, rehabilitation, social work, sociology, or speech and hearing; OR
 - ii) NYS licensure and current registration as a Registered Nurse and a bachelor's degree; OR
 - iii) A Bachelor's level education or higher in any field with five years of experience working directly with persons with behavioral health diagnoses; OR
 - iv) A Credentialed Alcoholism and Substance Abuse Counselor (CASAC).
 - b) Experience:
 - i) Two years' experience (a Master's degree in a related field may substitute for up to one year of experience) either:
 - A) Providing direct services to persons with serious mental illness, developmental disabilities, alcohol or substance abuse; OR
 - B) Linking persons who have serious mental illness, developmental disabilities, alcohol or substance abuse to a broad range of services essential to successfully living in a community setting.
 - c) Training and Supervision:
 - i) Specific training for the designated NYS Community Mental Health Assessment (community mental health suite of the interRAI) tool, the array of services and supports available, and the person-centered service planning process. Training in assessment of individuals whose condition may trigger a

need for HCBS and other supports, and an ongoing knowledge of current best practices to improve health and quality of life.

- ii) Must have supervision from a licensed clinician with prior experience in a behavioral health clinical or care management supervisory capacity.

The State may waive such qualifications on a selected basis and under circumstances it deems appropriate which may include care manager capacity issues.

5. For individuals enrolled in a HARP, the plan of care must include the following additional specific elements:
 - a) Documentation of results of the Home and Community Based Services (HCBS) Eligibility Screen (e.g., Not Eligible, Eligible for Tier 1 HCBS only, Eligible for Tier 1 and Tier 2 HCBS);
 - b) For individuals eligible to receive HCBS, a Summary of the NYS Community Mental Health Assessment; and
 - c) For individuals eligible to receive HCBS, Recommended HCBS that target the Individual's identified goals, preferences, and needs.
6. Health Homes must prepare plans of care for HARP members receiving HCBS that meet the requirements established by the Centers for Medicare and Medicaid (CMS) (see attached document under development).
7. A plan of care for HCBS is not required in instances where an enrollee:
 - a) is determined to be ineligible for HCBS; or
 - b) declines HCBS offered through the assessment process
8. For HARP Members that Opt-out of Health Home Services, but elect to receive HCBS, Health Homes may contract with MCOs to conduct NYS Eligibility Assessment and NYS Community Mental Health Assessment and to develop HCBS plans of care for members that opt out of Health Home care management services. The HCBS plans of care must still be developed in accordance with HCBS plan of care requirements.

E. Additional Health Home Standards and Requirements for Adult Home Class Members subject to the Stipulated Order and Settlement (requirements will be distributed once they are finalized)

F. Standards and Requirements for MCOs Related to the Provision of Health Home Care Management Services

1. MCOs must provide data to Health Homes and/or care management agencies to assist in outreach and engagement efforts, subject to any required agreements for sharing Medicaid Confidential Data in accordance with HIPAA and other state requirements regarding confidentiality.
2. MCOs must include information in the Health Home Welcome Letter that encourages potentially eligible members to enroll in a Health Home by including a brief summary of the services and benefits provided by the Health Home.
3. MCOs must continue periodic education to eligible members until member enrolls in a Health Home. This includes identifying opportunities for Health Homes to re-engage in outreach (e.g., appearance at emergency room or inpatient hospitalization) and reassigning the member to a Health Home.
4. MCOs must inform their provider network about Health Homes and how they can benefit eligible members.
5. After enrollment in the Health Home, MCOs must share current claims data and demographic information, including information received from New York Medicaid Choice, with Health Homes, and must enter the most recent demographic information in MAPP, in accordance with HIPAA and state confidentiality requirements.
 - a. MCOs must share information and performance data, including claims and encounter data, billing (or lack thereof) for monthly Health Home services, outreach and enrollment data, dashboards and other data made available through MAPP and hold periodic meetings with Health Homes and care managers to evaluate and improve Health Home performance.
6. MCOs must identify a single point of contact and establish communication protocols with Health Homes' single point of contact.
7. MCOs must have policies and procedures in place to inform and assist Health Homes in responding when critical events occur, including when a member 1) has presented at a hospital ER/ED and was not admitted 2) is admitted to inpatient hospital or 3) is in crisis and presents at a location that provides additional opportunities to outreach to a member. Such policies and procedures must incorporate information that will become available through MAPP referral portal and MAPP alerts. MCOs will be involved in the discharge planning process and make timely determinations on any requests for authorization (if applicable).
8. MCOs must have policies and procedures in place that provide for timely and effective communications between the MCO and the Member's care management provider when the Member receives services at an emergency room, Comprehensive Psychiatric Emergency Program, Crisis Respite, residential addiction program or inpatient setting, and to ensure that the Member is safely transitioned to the Member's subsequent setting when such services are no longer necessary. Such policies and procedures shall require that Members have timely access to follow-up care post-discharge and that the Member's plan of care is updated as necessary.
9. MCOs may use their own data in evaluating Department of Health (DOH) recommendations for Health Home assignments that are based on loyalty data.

10. MCOs must include a sufficient number of Health Homes in their network to serve all eligible Health Home members.
11. MCOs must assign DOH list-identified, MCO-identified or provider-identified members to the Health Home as soon as possible, but no longer than 45 business days from the date the member first appears on the DOH list so long as the Health Home has capacity to serve the member.
 - a. MCOs that do not meet this target must provide a report to the State identifying reasons for not meeting such and remedial actions to make improvements.
12. MCOs must submit claims for Health Home reimbursement to the State no less frequently than once every 14 days and make payment to the Health Home within 14 days of receipt of payment from the State.
13. MCO's will work with Assertive Community Treatment (ACT) programs and work with the local Single Point of Access (SPOA) agency to manage capacity and utilization of its members
14. The MCO is responsible for verifying Health Home eligibility for all members (this may be delegated by the MCO to the Health Home)
15. MCOs will review plans of care for consistency with assessment results and known member health needs, and make coverage and medical necessity determinations for services included in plans of care within timeframes established in the Medicaid Managed Care Model Contract.
16. MCOs will retain responsibility for reviewing member complaints and appeals and making timely determinations related to disputes regarding eligibility for Health Home services, the provision of Health Home services, the development of plans of care, the provision or arranging of services identified in the plan of care, and requests to transfer to another Health Home.
17. MCOs and Health Homes must establish clear lines of responsibility to ensure services are not duplicated.
18. MCOs shall require that Health Homes ensure that members have access to care management 24 hours per day, seven days per week for information, emergency consultation services and response in the community, if necessary.
19. MCOs will ensure that Health Homes offer members the choice of providers that include providers not part of the Health Home.
20. Upon prior notice to the Health Home, in a form and manner prescribed by the Agreement between the MCO and the Health Home, the MCO may transfer a Member to another state-designated Health Home upon request of the Member, if the Member relocates or transfers to a Primary Care Provider affiliated with another Health Home, or if the Member's Health Home loses its Health Home Designation for any reason or if another state-designated Health Home has successfully engaged the enrollee and the enrollee has consented to enrollment.
21. When a member requests to be transferred to another Health Home, the MCO shall timely transfer the Member to another Health Home, if available. The MCO shall ensure that the Health Home transfers the Member within a reasonable timeframe, but no later than 30 days. When a Member requests assignment of a new care manager, MCO will forward the request to the Health Home and follow up with the Health Home until the reassignment is completed.
22. The MCO shall transfer a member to another Health Home, if available, if the Health Home is not:

- Effectively providing or managing Health Home Services to the member
 - Achieving quality goals
 - Adhering to the MCO's protocols or
 - Meeting the member's needs, as determined by the MCO after consultation with the Member and the Health Home.
23. A MCO may not transfer a Member of a Health Home to another Health Home without consulting the Member, unless one of the criteria in paragraph 22 is the cause of the transfer.
24. If the MCO must transfer or deactivate a Member's enrollment in a Health Home and there is no other Health Home in the MCO's network or service area, the MCO shall immediately assume responsibility for providing care management, care coordination and execution of the Member's plan of care.
25. When a member is transferred or reassigned, or where a member is deactivated from enrollment in a Health Home, or in any other case where another entity assumes the care management responsibilities for a member, the MCO shall require through the Health Home Agreement that the Health Home cooperate with the entity assuming such responsibilities and transfer all relevant records and materials necessary for the continuation of care management services.
26. MCO shall monitor the performance of the Health Home and the Health Home service providers using the appropriate financial, programmatic and oversight tools and measures. All such tools and measures used shall be shared with the Health Homes to facilitate and foster proactive ongoing continuous improvement efforts in a form and manner prescribed by Agreements between the MCO and the Health Homes.
27. MCO shall not terminate the Agreement with a Health Home before:
- MCO notifies the Health Home of any deficiencies and works with the Health Home to develop a remedial plan for addressing such deficiencies and
 - notifying the State of any deficiency, attempted remediation, and termination.
28. The MCO shall support the State in building capacity in Health Homes by identifying Health Homes best suited for managing Members with SMI or functionally limiting SUD.
29. MCOs shall oversee and ensure that the Health Home undertakes engagement efforts for members lost to follow-up care pursuant to Section F (8) above.
30. For HARP Members that opt out of Health Homes but elect to receive HCBS:
- a. MCOs must contract with eligible providers to conduct the NYS Community Mental Health Assessment and develop the HCBS plan of care. The MCO may contract with a Health Home or other entity designated by the State for this purpose to conduct the initial NYS Eligibility Assessment and NYS Community Mental Health Assessment and to develop or make necessary revisions to a HCBS plan of care that meets the requirements of Centers for Medicare and Medicaid (CMS). The MCO will reimburse the Health Home or other State-designated entity no less than the rate established by the State for assessments and development of plans of care for HCBS.
 - b. The MCO shall ensure the assessment process is completed through its subcontracts with State-designated entities, within 90 days of the Member's declination to enroll in a Health Home. Such timeframe may be extended by the DOH as necessary for a limited period to manage the large

number of assessments anticipated during the initial HARP enrollment period.

- c. The MCO is responsible for providing care coordination for the implementation of the Member's plan of care. The MCO will be responsible for monitoring the implementation of the HCBS plan of care in accordance with HCBS and Medicaid Managed Care Model Contract requirements for care management of members in receipt of HARP and HCBS services. This includes ensuring the member has access to services that are included in the plan of care; periodic updating of the plan of care; and arranging for NYS Community Mental Health Assessment re-assessment at least annually.