

# New NY Programs 101

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HARP, QMP, SNP  
BEACON HEALTH OPTIONS

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# Topics

- > Overview
- > Health Homes
- > QMP
- > SNP
- > HARP
- > The HARP Process
- > Specialty Populations
- > What are HCBS Services?
- > Additional Programs & Services
- > FAQs

# Overview

# Changes to Medicaid in NY

- > Downstate New York / NYC is transitioning Medicaid into three plan options:
  - **QMP** – Qualified Medicaid Plan
    - > Base plan
  - > **SNP** – Special Needs Plan
    - > Available to members diagnosed with HIV / AIDS
    - > Receive all of the QMP benefits plus some additional support
  - > **HARP** – Health and Recovery Plan
    - > Members are qualified for this based on utilization history meeting an algorithm designed by the state
    - > Receive all of the QMP benefits
    - > Receive additional support and
    - > Additional benefits (HCBS services)

# Communication with Enrollees

- > The state will be sending out letters out to enrollees
  - > No set date
- > The letters will provide a high-level overview of transition
- > Changes go live July 1, 2016
  - > Members are auto-enrolled into HARP (based on state algorithm) and must call to opt-out.

# Health Integration

- > QMP: Referrals to Affinity CM and Beacon CM when BH or Medical concern, integrated rounds, access to BH and medical claims
- > HARP: Integrated Plan Of Care review, Affinity and Beacon assure member's recovery goals addressed and BH and Medical needs are met

# About Health Homes

# What is a Health Home?

- > A Health Home is a care management service
  - > All the individual's providers communicate with each other to address needs holistically
    - > Health records are shared among providers so that services are not duplicated or neglected – there is a health home consent form for this
      - > Beacon is being added to this for our members
  - > The health home assigns a care manager to each individual to manage this process
    - > Main goal of the care manager is to assure that an individual receives everything necessary to stay healthy, out of the emergency room and out of the hospital



# Who Gets a Health Home Assignment?

- > An enrollee can be eligible for a health home in any of the three (3) plans (QMP, SNP or HARP)
- > Medicaid enrollees are offered Health Home Care Management services if:
  - > They have two (2) or more chronic medical conditions
  - > They are identified as having an SMI
  - > They are in a SNP
  - > They are qualified for a HARP
- > The role of the health home is a little different based on if the member is in a QMP, SNP or HARP

# How Beacon Interacts with Health Homes?

- > Beacon is being added to our member's health home consent form so that health records can be shared
- > We will see the Health Home designation and assigned Health Home Care Manager in FLEXCARE and Connects
- > Beacon Case/Care managers will work with the assigned Health Home Care Manager
  - > Collaborate on SMI/SUD cases
  - > Participate in case conference
  - > Support service requests
  - > Facilitate housing
- > **Note:** *There is additional interactions based on the program the member is in (QMP, SNP, HARP)*

## Goals in Partnership with the Health Homes

- > Identify member needs and align appropriate individualized services to improve outcomes as outlined by Plan of Care
- > Reduce gaps in care, eliminate duplicative services, increase community tenure (remaining safely in the community), improve health outcomes, increase independence, engage natural supports, obtain and maintain stable housing, reduce negative life events (hospitalization, incarceration, eviction)

# About the Qualified Medicaid Plan (QMP)

# QMP Overview

- > QMP = Qualified Medicaid Plan
- > For all adults currently enrolled in Medicaid
- > Integrates all Medicaid state plan –covered services for mental illness and SUD and physical health conditions
- > If a member has 2 or more chronic conditions or an SMI, they are offered care coordination through an assigned health home

# QMP BH Benefit Package

Service	Currently FFS or MCO
Medically Supervised Outpatient withdrawal	MCO
Opioid Treatment Program (clinic)	FFS
Opioid Treatment Program (non-clinic)	MCO
Outpatient MH treatment	MCO for TANF and FFS for SSI
Comprehensive Psychiatric Treatment Program (CPEP)	FFS
Continuing Day Treatment	FFS
Partial hospitalization	FFS
Personal Recovery Oriented Services (PROS) - clinic treatment	FFS
Personal Recovery Oriented Services (PROS) - community rehab and support component	FFS
Personal Recovery Oriented Services (PROS) - Intensive Rehab Component	FFS
Assertive Community Treatment (ACT)	FFS
ICM/ Supportive CM (TCM being phased out)	FFS
Health Home Care Coordination	MCO
Inpatient hospital detox	MCO
Amb Detox	MCO
Inpatient Treatment (OASAS)	MCO for TANF and FFS for SSI
Rehab for residential SUD treatment supports	FFS
Inpatient Psych	MCO for TANF and FFS for SSI
Peer Services	FFS
Intensive Outpatient	FFS
Outpatient SUD Rehab	FFS
Buprenorphine	MCO
Outpatient SUD Clinic	FFS

# QMP BH Benefit Package

# SNP Overview

- > SNP = Special Needs Plan
  - > Type of Medicare Advantage Plan
- > Provides access to all the same services as QMP
- > Membership is limited to people with specific diseases or characteristics
  - > HIV SNP: Individuals diagnosed with HIV / AIDS and their eligible children whether or not they are also diagnosed with HIV / AIDS
- > To best meet the needs of the members, the following is tailored:
  - > Benefits
  - > Provider choices
  - > Drug formularies
- > SNP enrollees are offered the services of a health home care manager for care coordination



# SNPs that Qualify for HARP

- > There are some SNP enrollees that will qualify for HARP
- > These enrollees will stay designated as a SNP, but receive the additional benefits of a HARP
- > This will be indicated in FLEXCARE

# About the Health and Recovery Plan (HARP)

# HARP Overview

- > Harp = Health and Recovery Plans
- > Provides access to all the same services as QMP
- > Specialized and integrated managed care for adults meeting serious mental illness and SUD targeting criteria and risk factors
- > Provides access to an enhanced benefit package including an array of *HCBS* (home and community based services)
  - > Designed to assist in keeping the participant in home and community-based settings
- > For the first two (2) years of the program the state will reimburse the health plans for HCBS services.
  - > There is a max dollar amount per year for a member

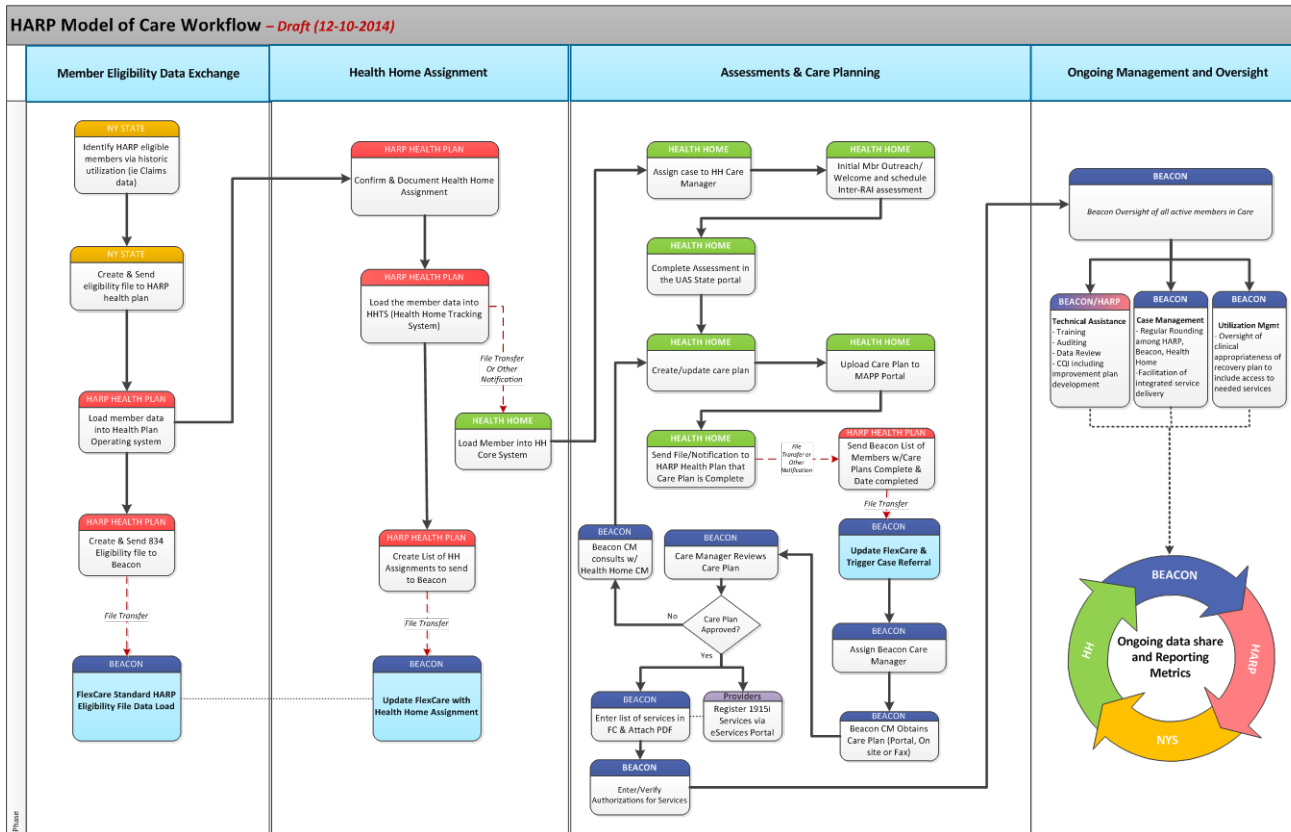
# Health Homes and HARP

- > Health Home's role takes on additional requirements with HARP enrollees
- > When the enrollee agrees to the Health Home assignment, the health home care manager completes an assessment to identify additional needs of the enrollee
- > If the assessment indicates that the enrollee could benefit from HCBS services, the care manager completes an assessment
- > The Health Home Care Manager then creates a **care plan (POC)** for the enrollee
- > The Health Home care manager works with the care managers at the health plan and Beacon to coordinate care

# Health Home Requirements for HARP

- > All HARP enrollees will be offered enrollment into a Health Home and assigned a Health Home care manager
- > Health Home will initiate person-centered planning process to determine a plan of care that will include completion of an assessment for 1915(i) like needs. Process must comply with federal conflict free case management requirements.
- > Health Home care management services include:
  - > Care coordination and health promotion
  - > Comprehensive transitional care from inpatient and other settings
  - > Individual and family support, which includes authorized representatives
  - > Referral to community and social support services, if indicated
  - > Use of HIT to link services
  - > Planning and coordination to identify needed 1915(i) HCBS services
  - > Brokering to obtain and integrate HCBS services and supports
  - > Advocacy to resolves issues that impede access to needed service

# HARP Process



# HARP Process

## > NY State

- > Identifies an enrollee as HARP eligible
- > Creates and sends the eligibility file to the HARP health plan

## > HARP Health Plan- **Affinity**

- > Loads member data into operation system
- > Creates and sends an eligibility file to Beacon
  - > Beacon loads the eligibility file
- > Confirms and documents the Health Home (HH) assignment
- > Loads the member data into *MAPP*
  - > Beacon updates the HH assignment
  - > Health Home loads the member into the HH HIT system

# HARP Process Cont'd

## Health Home

- > Scrubs member data & determines downstream provider capability
- > Member assigned to HH Care Manager or downstream provider
- > Completes the HH assessment in HH HIT Platform
  - > *If HCBS services are indicated-* HH administers the Inter-Rai assessment
- > Updates Care Plan and uploads it to the MAPP portal
- > Notifies Affinity that the care plan is complete

Affinity sends Beacon list of members with care plans completed and date completed



# HARP Process Cont'd

## > Beacon

- > FLEXCARE (FC) updated and Case referral triggered
- > Care Manager (CM) assigned
- > CM obtains the HH care plan
- > CM reviews the care plan jointly with the health plan
- > *Is the Care plan approved*
  - > *If yes:*
    - > CM notifies HH of approval
    - > CM enters the list of services into FC & attaches care plan
    - > Add / verify authorizations
    - > Provides continuous oversight of member
  - > *If no:*
    - > CM reaches out to HH to provide feedback
    - > HH reworks the care plan based on feedback and resubmits

# Ongoing Coordination

## > Technical Assistance

- > Training
- > Auditing
- > Data Review
- > CQI

## > Case Management

- > Regular rounding among Beacon, HH and Health Plan
- > Facilitation of integrated service delivery

## > Utilization Management

- > Oversight of Clinical appropriateness of recovery plan

# Specialty Populations

# AOT

- > Assisted Outpatient Treatment
- > Individuals assessed as threat to themselves or others may receive court ordered treatment. Refusal to participate in court ordered care plan (which always includes either HH CC or ACT CM) can result in court mandated hospital evaluation
- > Members with AOT will be identified with a flag in FLEXCARE for tracking/monitoring
- > With consent Beacon CM will work with AOT monitors (LGU SWs who oversee AOT) and HH to ensure access to care, compliance and track outcomes
- > Relias Training code: *BHO.NYAOT.LiveTrg*

# FEP

- > First Episode Psychosis: First psychotic break experienced by a young adult. Connection to appropriate resources has been shown to decrease the experience/severity of symptoms long term
- > With appropriate consents - work with HHs and community programs like NYC START to identify FEP and link to specially trained community providers (ONTRACK is the training)
- > Partner with Plan to link to PCP
- > Assign Beacon ICM, to monitor and track, determine HARP eligibility
- > Relias Training code: *BHS.SpecPop.FEP*

# TAY

- > Transitional Age Youth – typically refers to youth between 16-24 who are moving out of children’s treatment system into the adult system.
- > Adult HARPS and Adult HHs begin at age 21
- > **Identification:**
  - > Beacon will work with Affinity and the State to identify youth who will be “aging out” of their care.
  - > Children’s HHs can support identification of TAY
  - > Partnerships with Foster Care agencies
  - > Adolescent Skill Centers: For TAY with SMI/SED

# TAY (cont'd)

- > **Plan:** Specially trained CM will work with HH, Affinity, PCP and existing treatment team to design a recovery plan and work with member through case conferences to get “buy in” and improve compliance.
- > **Interventions:** Care Plan should include, linkage to PCP, educational and vocational services and support goals of independent living and recovery
- > Relias Training Code: *BHO.NYTAY.LiveTrg*

# SUD

- > Transition of ambulatory and residential services to managed care
- > SUD are HARP eligible based on high service utilization
- > LOCADTR to replace ASAM in determining levels of care
  - > More carved-in services
  - > A large number of providers experiencing managed care for the first time



# HIV/AIDS

- > HIV SNP HARP eligible members have access to HCBS
- > CM's with specialized training
- > Linkage to HASA via Health Home of SNP
- > Designated AIDS Centers: Outpatient and Inpatient treatment centers with Integrated BH and Medical Care

# Programs & Services

# ACT: Assertive Community Treatment

- > This is a team of people from the fields of Psychiatry, nursing, psychology, social work, substance abuse and vocational rehabilitation
- > They collaborate to provide an individual with combined services based on the individual's goals
  - > As the goals change, the services are continually adjusted to be able to support the individual's changing needs.
- > An ACT team works with the member outside the clinical setting.
  - > They can come to an individual's home, work or other setting
- > A member accesses ACT via the NYC Department of Health and Mental Hygiene SPOA
- > This service is available to all Medicaid enrollees

# PROS: Personalized Recovery Oriented Services

- > The PROS program is designed for individuals with severe mental illness. It includes four (4) components:
  1. Community Rehabilitation and Support
  2. Intensive Rehabilitation
  3. Ongoing Rehabilitation
  4. Clinical Treatment services
- > The overall goals of the PROS program is to improve functions, reduce relapse, increase employment, attain education and secure preferred housing.
- > This service is available to all Medicaid enrollees

# HCBS Overview

- > HCBS = Home and Community Based Services
- > Services Include:
  - > Crisis Respite,
  - > Educational and Vocational Habilitation and Rehabilitation,
  - > Peer and Family Support Services,
  - > Community Rehab Services,
  - > Habilitation Support
  
- > How a member gets access: InterRAI Screen and Full Assessment and Plan of Care completed by Health Home CMA
  
- > Beacon CM Oversight: Review POC, HCBS: Congruent to Assessment, Notification and/or Authorization: Assessment to HCBS 45 days

# Health Home Plan of Care for HCBS Requirements

- > Stated Goal
- > Preferences and Strengths
- > Functional Needs (Summary of InterRAI results)
- > Community Networks and Supports
- > CM Interventions and timeframes
- > Member signature
- > Identified HCBS services and minimum of 2 providers
- > PCP and BH Providers (Contact and input if possible)
- > Family Collateral when applicable
- > Individualized and Person-Centered

# LOCADTR

- > Effective 10/1/15
- > Level of care tool completed by provider for all levels of SUD services for Medicaid benefit
- > Provider and UR clinician complete SUD review and LOCADTR 3 result is shared; when override is required it will be for three reasons:
  1. LOC not available
  2. Provider does not feel LOCADTR LOC is clinically appropriate
  3. Court Ordered
- > All NYC Staff, Prior Authorization, Float and Pas assigned to NY will be trained and have HCS access to LOCADTR

# Services for members identified with SMI and Co-occurring disorders

- > ACT: Eligibility, Access, Universal Referral Form
- > PROS (IR, ORS, Clinic Treatment)
- > Ambulatory Detox
- > CPEP: Mobile Crisis, EOB, Interim and Crisis Visits
- > Mobile Crisis: Access via MHA Lifenet



# Peer and Peer Services

- > Staff who identify as a person with lived BH experience that provides advocacy and services
- > Plan partnership Howie the Harp, NYAPRS and NAMI
- > Plan Peers for health care coaching, recovery support and Health Care literacy
- > Peer Support Services is an HCBS

# Full List of Behavioral Health Services

All of our members will have access to services to help with mental health, or to help with alcohol or other substance use issues. (For SSI members, all these services are new to the plan)

These services include:

## **Mental Health Care**

- > Intensive psychiatric rehab treatment
- > Day treatment
- > Clinic continuing day treatment
- > Inpatient and outpatient mental health treatment
- > Partial hospital care
- > Rehab services if you are in a community home or in family-based treatment
- > Continuing day treatment
- > Personalized Recovery Oriented Services
- > Assertive Community Treatment Services
- > Individual and group counseling
- > Crisis intervention services

## **Substance Use Disorder Services**

- > Inpatient and outpatient substance use disorder (alcohol and drug) treatment
- > Inpatient detoxification services
- > Opioid, including Methadone Maintenance treatment
- > Residential Substance Use Disorder Treatment
- > Outpatient alcohol and drug treatment services
- > Detox Services

# Information about Behavioral Health Home and Community Based Services (BH HCBS)

- > HARPS will include new Behavioral Health Home and Community Based Services. BH HCBS can help you with life goals such as employment, school, or other areas of your life you want to work on. To find out if you qualify, a Health Home Care Manager must complete a brief screening with you that will show if you can benefit from these services. If the screening shows you can benefit, the Care Manager will complete a full assessment with you to find out what your whole health needs are including physical, behavioral and rehabilitation services.
- > BHHCBS includes:
  - > Psychosocial Rehabilitation (PSR) – helps you build skills needed to reach your goals.
  - > Community Psychiatric Support and Treatment (CPST) - is a way to get services you need at a location of your choosing, such as your own home.
  - > Habilitation Services - helps you learn new skills in order to live independently in the community.
  - > Family Support and Training - is help for the people in your life who help you