

Collaboration with Care Managers and Managed Care



NYAPRS
**7TH ANNUAL RECOVERY AND
REHABILITATION ACADEMY**

NOVEMBER, 2016

Agenda



- Define roles
- HARP
- HCBS
 - Workflow
- Partnership
- Stakeholder Perspectives
 - CMA
 - HCBS
 - MCO
 - DOH, OMH & OASAS

Erica Bou, LMHC, CRC
HCBS Administrator
UnitedHealthcare
Community Plan NY



Scott Ebner, LMSW
Executive Director
Circare



Nicole Haggerty, LMHC
Director, Bureau of Rehabilitation
Services and Care Coordination
Office of Mental Health



Deborah Rose, PsyD
Director, Behavioral Health Home &
Community Based Services
Healthfirst



Who's who?



- **Managed Care Organizations (MCO)**
 - DOH awarded HARP benefit plan
 - Contracts with Lead Health Home
- **Lead Health Home**
 - Designated by DOH
 - Contracts with MCO
 - Subcontracts to Care Management Agencies for Health Home services
- **Care Management Agency**
 - Employs Care Managers
- **Care Manager**
 - Responsible for care coordination, assessment and referrals
- **HCBS Provider**
 - Wrap around services

HARP Criteria



- 21 years old +
- Medicaid enrolled
- DOH identified based on utilization, claims and diagnosis history
- Serious mental health and/or substance use disorder
- Potential eligibility for Home and Community Based Services (BH HCBS)

Behavioral Health

Home & Community Based Services



- Habilitation/Residential Supports
- Psychosocial Rehabilitation (PSR)
- Community Psychiatric Support and Treatment (CPST)
- Educational Support Services
- Employment Support Services
 - Prevocational
 - Transitional Employment Support
 - Intensive Employment Support
 - Ongoing Supported Employment
- Peer Supports/Empowerment
- Family Support and Training
- Crisis Respite
 - Short Term Crisis Respite
 - Intensive Crisis Respite

Adult Behavioral Health HCBS Workflow



- HH Care Manager conducts eligibility assessment on HARP enrolled member (H1)
- Determines HCBS eligibility and, with member, identifies services
- Creates Level of Service Determination request
- Submits LOSD to MCO and works with MCO Care Manager to identify available HCBS providers

HH Care Manager receives written LOSD and makes referral to HCBS provider(s) of member's choice

- Within 90 days completes complete Community Mental Health Assessment (CMHA)
- Completes full Plan of Care
- Sends full POC to MCO

Continues to coordinate with member, HCBS providers, treatment team and MCO Care Manager

What is a PARTNERSHIP?



- An arrangement where parties, known as partners , agree to cooperate to advance their mutual interests. Organizations may partner together to increase the likelihood of each achieving their mission and to amplify their reach. (Wikipedia Dictionary)



Treatment Team

Health Home Care Manager

MCO

HCBS

Primary Care & Medical Providers

DOH
OMH
OASAS

HARP Member

Health Home & CMA: Lessons Learned



- Think broadly about your relationship to the managed care company (MCO)
 - Appreciate broader context and possibilities of MCO relationship
 - Understand the MCO requirements and align value
 - Plans focus – outcomes and decreased cost
 - Align goals of recovery and rehabilitation
 - Plans' desire to see members obtain HARP services
 - Plans' accountability to the state
 - Utilize best practice and person centered services.
 - Following best practice guidelines helps your staff structure service plans and communication.

HCBS Relationship with Health Home & CMA



- Market to care managers and potential recipients
- Develop materials
 - Create a 'cheat sheet'
- Understand Plan of Care and align Service Plan
- Utilize Care Managers
 - CMA can facilitate communication among the team
 - CMA can outreach disengaged members
- Hold care managers accountable
- Find creative ways to communicate and involve care managers

What has worked - MCO perspective



- Collaboration and Communication
- Identifying and reaching out to key stakeholders
- Being flexible throughout the process
- Willing to offer assistance on any level
- Ongoing training for all
- Aligning with colleagues
- Sharing resources



What has not worked - MCO perspective



- Lack of flexibility on an already complicated process
- Lack of communication with Health Home Care Managers
- Unwilling to collaborate
- Competition



Collaboration with the State



- Specific suggestions for change
- Specific questions
- Knowing when to reach out
- Partnerships with other key stakeholders
- Pilots
- Offering solutions
- Being flexible in both directions

Understanding Your Resources



- Health Home/Managed Care Organization Workgroup – includes CMAs as well
- Health Home weekly call
- Roundtables – Providers and MCOs
- Conferences
- List serve and website familiarity – DOH, OMH, MCTAC, others.
- Face to face vs. webinar, managing time and staff
- Learning Collaboratives

Spirit of Successful Collaboration



- Solution- Focused
- Active listening
- Honest and productive feedback
- Understanding roles and responsibilities of all players
- Discovering best practices and sharing
- *Understanding Person-Centered Planning: The individual is in the driver's seat and we are all working to support their recovery journey.*



Contacts



Erica Bou

Erica.Bou@uhc.com

Scott Ebner

sebner@cir.care

Nicole Haggerty

Nicole.Haggerty@omh.ny.gov

Deborah Rose

drose@healthfirst.org