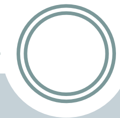
Managed Care and Self-Care

HARPs, Health Homes, and Managing Well-being Through the Changes



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NYAPRS CONFERENCE, 2015

Goals of Presentation

- Learn about changes coming to Medicaid in NY and what you have to do about it
- Learn how other states have approached similar changes to Medicaid, including necessary advocacy and connections to social services and social movements
- Learn about personal and community advocacy channels relevant to the changes in managed care
- Discuss methods of self-care relevant throughout, and in spite of, changes to healthcare delivery system.

Definitions of Terms

- Managed Care Organization (MCO): company that manages the finances, policies, and organization of health care for individuals. Can be private or nonprofit, and may have many different “product lines” to meet the needs of different consumers
- Affordable Care Act (ACA): Often referred to as “Obamacare”; a Federal healthcare reform that made wide-sweeping reforms to options for delivering healthcare
- Health Home (HH): A network of providers across the healthcare spectrum organized by a central agency that provides care management to individuals and connects them with providers and supports within a network of care

Definitions of Terms

- Health and Recovery Plan (HARP): Special “product” within a managed care organization that focuses specifically on needs for people with behavioral health diagnoses and service priorities
- Home and Community Based Services (HCBS): A set of services chosen by NYS to promote recovery and community living for individuals with behavioral health diagnoses and service priorities

Need for Systems Change in NY

- In 2011, Governor Cuomo hired a new Medicaid Director to examing healthcare spending; highest in country with the lowest outcomes and highest institutionalization
- Medicaid Redesign Team focused on the “Triple Aim” of the ACA: improving quality and public health while lowering cost
- Social determinants including housing and access to public resources, as well as recovery-oriented services, have been the priority
- Payment reform must prioritize efficiency and flexibility.

States' Experience with Managed Care

- Managed Care became associated with waste and corporate in the 1990s, and many states that had moved to Managed Care as a payment system took some power back – or "carved out" services – from MCOs
- Some states kept Managed Care with tighter regulatory controls, or divested MCO control of certain services for public benefit recipients
- Philosophy of state control over public benefits like Medicaid and Medicare is about control over who has control over state funds
- Problems arise when state infrastructure and knowledge limit the success of the management of funds and services for public benefits
- States are now looking to MCOs again to help control state healthcare spending, counter decreasing investments in a state workforce, integrate services and administration, and focus on qualitative and quantitative outcomes of healthcare delivery.

Common Pitfalls in Medicaid and Medicare Anticipated by NYS

- No limits on administrative expenses
- Lack of focus on community providers with historical expertise in service delivery but not market sophistication
- Reliance on process and medical outcomes without focus on social outcomes or ones that are more difficult to measure
- Lack of integration with other services and benefits
- Reduction in care management and service coordination in favor of MCO administration of these benefits
- No commitment to reinvestment of potential savings into future services
- Divestment of state control in outcomes and process

Systems Advocacy and Historical Experiences

- Rights of individuals in accessing appropriate services
  - Cultural competence
  - Logistical accessibility
  - Services reflective of philosophy of system design (person-centered, recovery-focused, etc.)
  - Denial of services or access to preferred providers

Systems Advocacy and Historical Experiences

- Contracting and payment concerns for providers
  - Prompt payment of claims to ensure people can continue working and taking new clients
  - Training and ongoing facilitation of new payment mechanisms like electronic billing
  - MCOs responsive to provider concerns – possible to work in tandem for joint advocacy around regulatory constraints
  - Favoring of larger providers because of ease of contracting, not taking into account outcomes and preferences of individuals

Understanding Changes to Medicaid Behavioral Health Care in New York

Medicaid Managed Care
Behavioral Health Care

- Medicaid is changing to cover more mental health and substance use disorder services
- Medicaid Managed Care Plans will include more mental health and substance use disorder services called "Behavioral Health Services"
- People who stay with their current Medicaid Managed Care Plans will not need to change doctors or other providers unless they want to

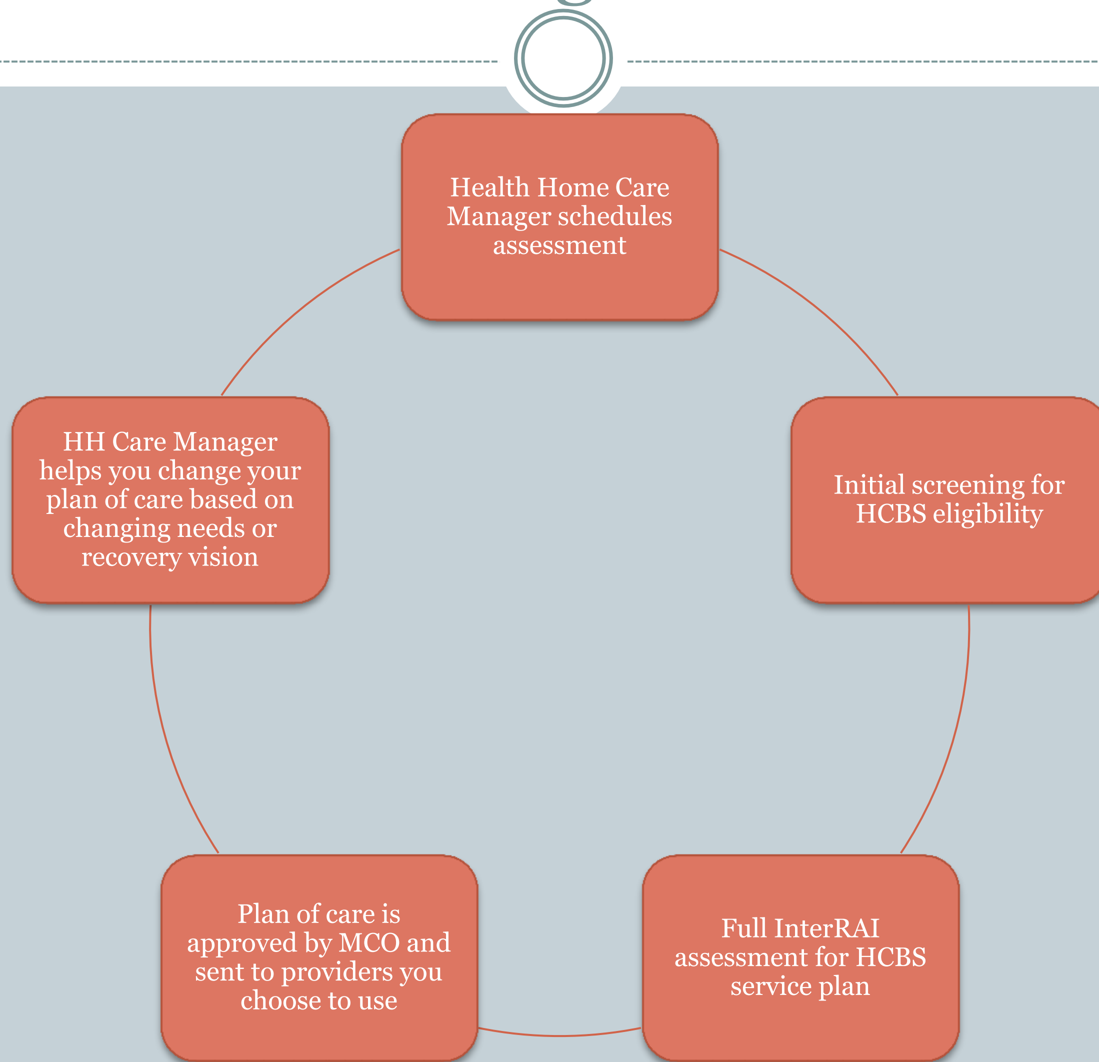
What is a Health and Recovery Plan

- A HARP is a managed care plan with extra services and supports focused on people with serious mental health and substance use needs.
  - You keep all the benefits and services you get now from your health plan
- HARPs offer enhanced benefits for people with serious mental illness and substance use disorders that are not available in other plans
  - You may be eligible for Home and Community Based Services (HCBS) which are ONLY available in HARPs.
  - These are services that you choose and are tailored to your needs
- New York State and New York Medicaid Choice will send letters to people eligible for HARPs

How are HARPS different form other Managed Care plans?

- HARPS specialize in serving people with behavioral conditions
- HARPS cover additional rehabilitative services called Home and Community Based Services (HCBS)
- Some people in HARPS will be eligible for HCBS services
- A care manager will help people in HARPS and service providers work together

Health Home Care Management in Managed Care



How do I enroll in a HARP?

- **Everyone eligible for HARP will have the chance to join**
- If your Plan now has a HARP, you don’t have to do anything if you want to be in the HARP. You will be automatically enrolled.
  - If you DON’T want to be in the HARP, you will need to respond to your letter to opt out.
- If your Plan does not have a HARP, you will need to take action.
  - You will need to respond to your letter to indicate you want to switch to a plan that has a HARP.
- If you have an HIV Special Needs Plan, you can stay in your plan and get HCBS. You do not need to take action to do this
  - If you want to switch to a plan with a HARP, you will need to respond to your letter to indicate you want to switch.

Health and Recovery Plan (HARP) Enrollment

Passive

- Some people who are eligible for HARP enrollment do not have to do anything to join- they will be automatically enrolled in the HARP that is run by your managed care company

Active

- Other people who are eligible for HARP will have to choose to enroll in a HARP- if the company that runs their current Medicaid managed Care plan does not offer a HARP
- These people will be informed that they are eligible to join a HARP
- How to join a HARP
- Who to call if they want to join a HARP

Home and Community Based Services

- Rehabilitation
  - Psychosocial Rehabilitation
  - Community Psychiatric Support and Treatment (CPST)
- Habilitation
- Crisis Intervention
  - Short-Term Crisis Respite
  - Intensive Crisis Intervention
- Educational Support Services
- Individual Employment Support Services
  - Prevocational
  - Transitional Employment Support
  - Intensive Employment Support
  - On-going Supported Employment
- Empowerment Services -- Peer Supports
- Support Services
  - Family Support and Training
  - Non Medical Transportation
- Self Directed Services Pilot

Home and Community Based Services (HCBS) Assessment

- In order to get HCBS, people will need an assessment
- Assessment shows if people are eligible for HCBS and which HCBS they need
- People in HARPs will have a Health Home Care Manager who will complete the assessment
- Care managers will also help people in HARP make a Plan of Care, which identifies life goals and services people need to reach those goals
- Personal choice will be very important in making a Plan of Care

When do these changes happen?

Medicaid eligible people who live in NYC

- Medicaid Managed Care plans are scheduled to begin coverage of expanded behavioral health care services in October 2015, for NYC
- Home and Community Based Services will become available in January 16 to eligible people in HARP's and SNPs
- Rest of state changes will begin July, 2016

Self Advocacy

- HCBS Assessment
- Individual's interest should be reflected in the plan of care
- Care managers should not determine the services for the consumer
- Plan of care must be approved and signed by consumer in order to be processed and approved by managed care company

Resources for Advocacy

- NY Health Access: http://www.wnylc.com/health/17/

  Hosted by: Empire Justice Center, Legal Aid Society, NY Legal Assistance Group, Western NY Law Center
- Mental Health Association NYS, for access, social security, and issues related to stigma: www.mhanys.org ; 518-427-8676
- Community Health Advocates, run by Community Service Society NY; resource guides and helpline: www.communityhealthadvocates.org; 888-614-5400
- For more information, see "The Advocate's Guide to the Medicaid Program":
  - http://www.medicaidguide.org/