Foundations: Managed Care Transition and Adult BH HCBS Implementation

Presented by McSilver/MCTAC Technical Assistance Training Partners

Adult BH HCBS Roadmap Partners

Setting The Stage

Medicaid Expenditures: 2013

Medicaid Redesign Team (MRT)

- To address underlying health care cost and quality issues in New York's Medicaid program, Governor Andrew M. Cuomo created the Medicaid Redesign Team to develop a multiyear reform plan. He invited key Medicaid stakeholders to the table in a spirit of collaboration to see what could be achieved collectively to change course and rein in Medicaid spending, while at the same time improving quality.
- Medicaid Redesign is premised on the idea that the only way to really control costs is to improve the health of program participants. The MRT action plan launched a series of innovative solutions designed to better manage care and reward providers that help keep people healthy.
- More than 200 initiatives were created as a result of MRT. These initiatives will implement programmatic changes to the way health care is provided, reimbursed and managed to ensure that we are providing quality care in the most efficient manner.

Initiatives

Triple Aim

- Improve Member Experience
- Improve Quality/Outcomes
- Decrease Cost

Behavioral Health Transition to Managed Care

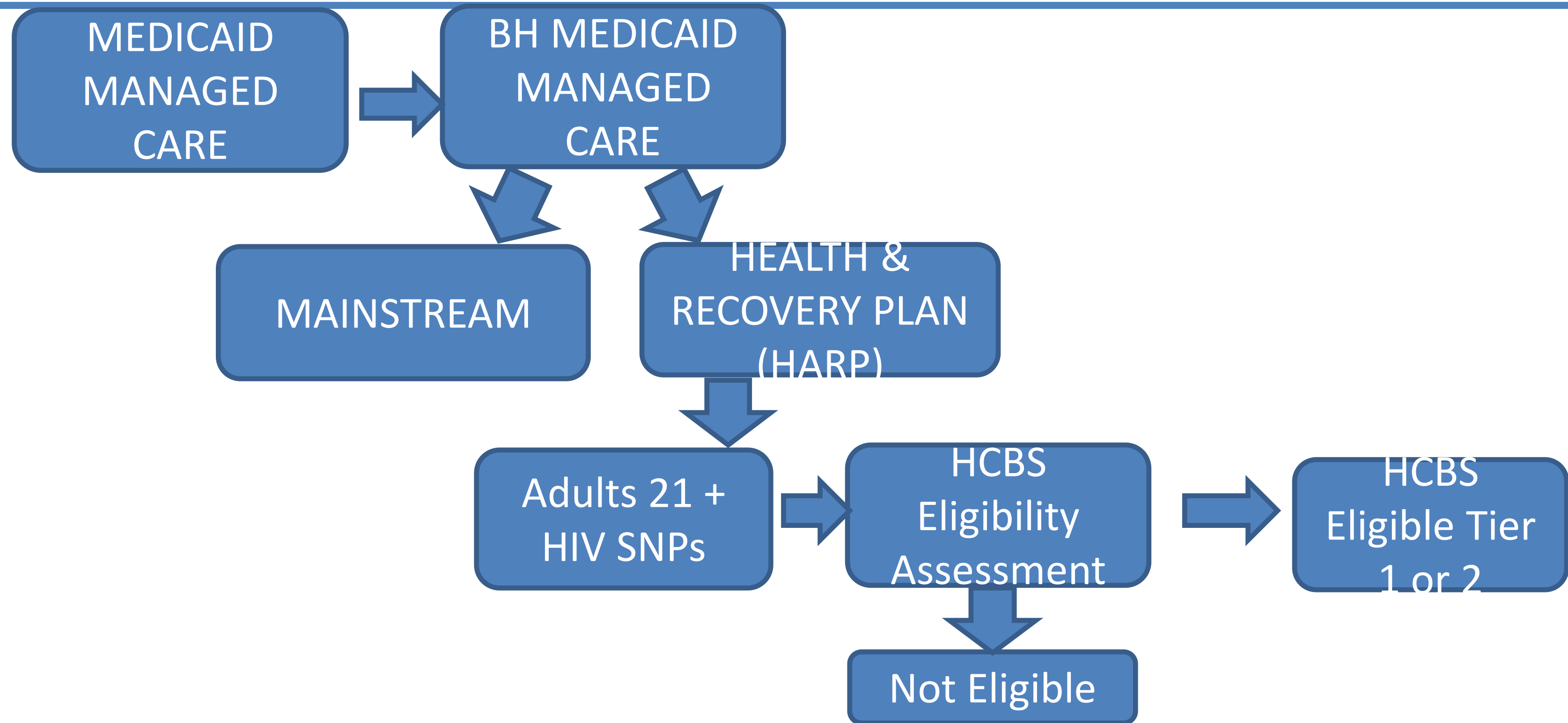
- **Mainstream Medicaid Managed Care (MMC) Plans:** All adult recipients who are eligible for Medicaid Managed Care (excludes Medicare recipients and certain other populations), will receive the full physical and behavioral health benefit through managed care.
  - October 1, 2015, plans started to cover expanded behavioral health benefits in New York City.
  - July 1st, 2016, plans started to cover expended behavioral health benefits in Rest of the State (ROS).
  - Consumers enrolled in a MMC whose behavioral health benefit was covered under Fee for Service Medicaid through SSI will begin receiving these benefits through the MMC plan.

Behavioral Health Transition to Managed Care Cont.

- **Health and Recovery Plans (HARP) and HIV Special Needs Plans (SNP):** Adults enrolled in Medicaid and 21 years or older with select Serious Mental Illness (SMI) and Substance Use Disorder (SUD) diagnoses having serious behavioral health issues will be eligible to enroll in a new type of health plan, HARP.
  - These specialty lines of business operated by the MCO will be available statewide. Individuals meeting the HARP eligibility criteria who are already enrolled in an HIV Special Needs Plan may remain enrolled in the current plan and receive the enhanced benefits of a HARP. HARPs and SNPs will arrange for access to a benefit package of Home and Community Based Services (HCBS) for members who are determined eligible.
  - HARPs and SNPs will contract with Health Homes, or other State designated entities, to develop a person-centered care plan and provide care management for all services within the care plan, including the HCBS.
  - January 1, 2016 – Adult BH HCBS became available for eligible individuals in HARPs and HIV SNPs in New York City
  - October 1, 2016 – Adult BH HCBS became available for eligible individuals in HARPs and HIV SNPs in Rest of State (ROS)

Program/Services that transitioned to Managed Care

- Inpatient psychiatric services in Article 28 facilities
- Part 599 clinics and behavioral health services in Part 598 integrated clinics
- Personalized Recovery Oriented Services (PROS) programs operated under Part 512
- Continuing Day Treatment (CDT) programs operated under Part 587
- Intensive Psychiatric Rehabilitation Treatment (IPRT) programs operated under Part 587
- Assertive Community Treatment (ACT) programs operated under Part 508
- Partial Hospitalization (PH) programs operated under Part 587
- Inpatient Psychiatric Hospitalization Services operated under Parts 580 or 582
- Comprehensive Psychiatric Emergency Programs (CPEPs) operated under Part 590
- Behavioral Health Home and Community Based Services (BHHCBS):
- OASAS Clinic
- OASAS Opioid Treatment Program
- OASAS Outpatient Rehab
- OASAS Residential Redesign


MEDICAID MANAGED CARE
BH MEDICAID MANAGED CARE
MAINSTREAM
HEALTH & RECOVERY PLAN (HARP)
Adults 21 + HIV SNPs
HCBS Eligibility Assessment
HCBS Eligible Tier 1 or 2
Not Eligible

Adult Behavioral Health Home and Community Based Services (HCBS)

Adult BH HCBS Menu of Services

- Rehabilitation
  - Psychosocial Rehabilitation (PSR)
  - Community Psychiatric Support & Treatment (CPST)
- Habilitation
- Crisis Respite
  - Short-Term Crisis Respite
  - Intensive Crisis Respite
- Education Support Services
- Individual Employment Support Services
  - Pre-Vocational
  - Transitional Employment
  - Intensive Supported Employment
  - Ongoing Supported Employment
- Empowerment Services – Peer Support
- Family Support & Training
- *Non Medical Transport (can only be provided by Medicaid Transportation Vendors)

Adult BH HCBS Value/Core Principles

Values & Core Principles

The development of Health and Recovery Plans (HARPs) is intended to promote significant improvements in the Behavioral Health System as we move into a recovery- based Managed Care delivery model. A recovery model of care emphasizes and supports a person's potential for recovery by optimizing quality of life and reducing symptoms of mental illness and substance use disorders through empowerment, choice, treatment, educational, employment, housing, and health and well-being goals.

The Behavioral Health Home and Community Based Services (BH HCBS) provide opportunities for adult Medicaid beneficiaries with mental illness and/or substance use disorders to receive services in their own home or community. Implementation of BH HCBS will help to create an environment where managed care plans, service providers, plan members, families, and government partner to help members prevent and manage chronic health conditions and recover from serious mental illness and substance use disorders.

Values & Core Principles

- Person-Centered Care
- Recovery-Oriented Services
- Integrated Services (Physical & Behavioral Health)
- Data-Driven
- Evidence-Based
- Trauma-Informed
- Peer Supported
- Culturally Competent
- Flexible & Mobile
- Inclusive of Social Network
- Coordination & Collaboration

HCBS Modalities & Settings

- Only Psychosocial Rehabilitation and Family Support & Training may be provided in a group format. All other services must be provided 1:1.

- In keeping with the Values and Core Principles of HCBS, services should be provided in home and community based settings whenever possible.

Adult BH HCBS Eligibility

Adult BH HCBS Eligibility

- State Identified HARP enrolled Medicaid beneficiaries age 21 and older
- Individuals enrolled in HIV SNPs determined by the State to be HARP-eligible
- Meets eligibility criteria on the HCBS Eligibility Assessment
  - Tier 1 -- Services include employment, education and peer supports services
  - Tier 2 -- Includes the full array of Adult BH HCBS
- “H” Codes indicate HCBS eligibility - available on EPACES

Main EPACES HARP/HCBS Codes

- H9 - HARP eligible but pending enrollment. This person has been determined to be eligible for a HARP.

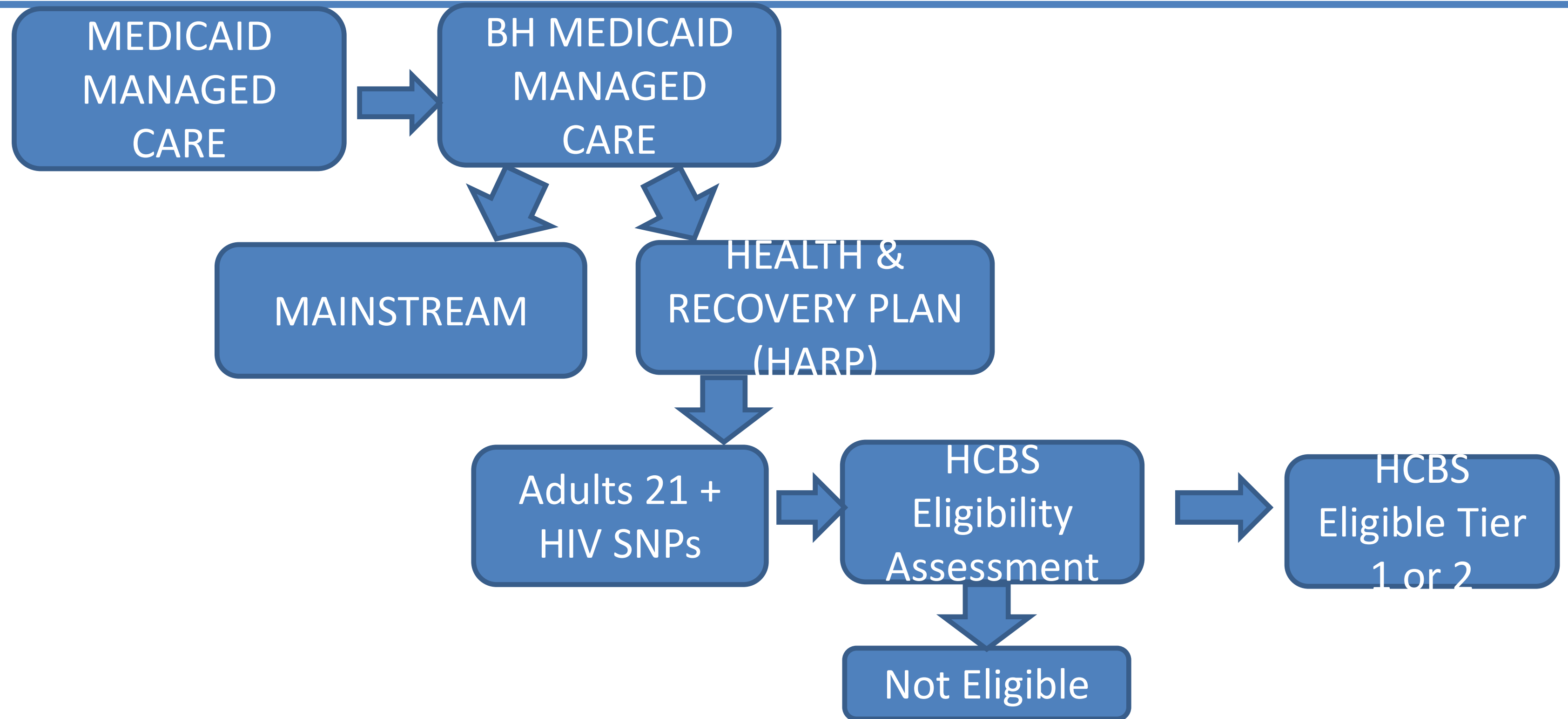
- H1 - HARP enrolled
  - *At this time HH should begin the NYSCMHA process.*

Adult BH HCBS eligibility – HARP enrolled

- H2 –This code identifies the person as enrolled in a HARP. It also indicates that the person has been assessed and determined to be eligible for Tier 1 HCBS services (peer supports, employment supports, education supports).

- H3 –This code identifies the person as enrolled in a HARP. It also indicates that the person has been assessed and determined to be eligible for Tier 2 HCBS services (All HCBS services)

Additional EPACES HARP/HCBS codes can be found in eMedNY website under MEVS/DVS Provider Manual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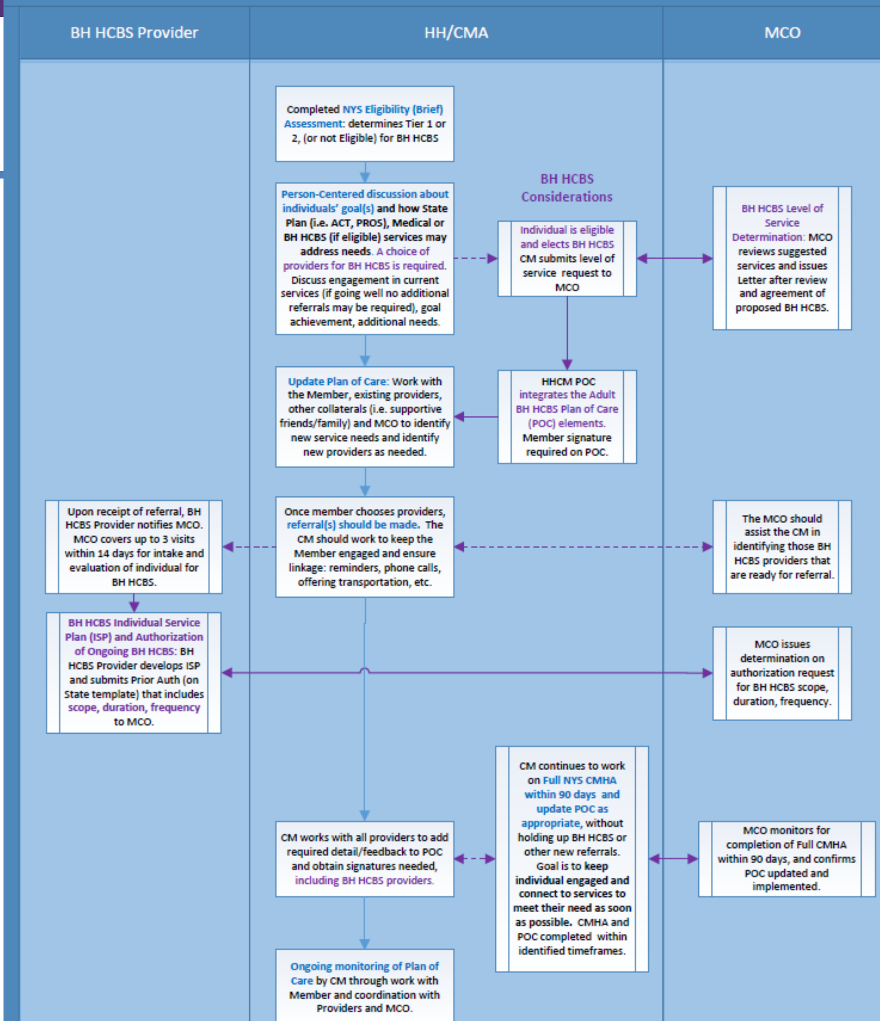
From NYS Community Mental Health Assessment (CMHA) to BH HCBS Referral:
Suggested Workflow Focused on Engagement for HARP members
BH HCBS Provider
HH/CMA
MCO
Completed NYS Eligibility (Brief) Assessment: determines Tier 1 or 2, (or not Eligible) for BH HCBS
Person-Centered discussion about individuals' goal(s) and how State Plan (i.e. ACT, PROS), Medical or BH HCBS (if eligible) services may address needs. A choice of providers for BH HCBS is required. Discuss engagement in current services (if going well no additional referrals may be required), goal achievement, additional needs.
BH HCBS Considerations
Individual is eligible and elects BH HCBS CM submits level of service request to MCO
BH HCBS Level of Service Determination: MCO reviews suggested services and issues Letter after review and agreement of proposed BH HCBS.
Update Plan of Care: Work with the Member, existing providers, other collaterals (i.e. supportive friends/family) and MCO to identify new service needs and identify new providers as needed.
HHCM POC integrates the Adult BH HCBS Plan of Care (POC) elements. Member signature required on POC.
Upon receipt of referral, BH HCBS Provider notifies MCO. MCO covers up to 3 visits within 14 days for intake and evaluation of individual for BH HCBS.
Once member chooses providers, referral(s) should be made. The CM should work to keep the Member engaged and ensure linkage: reminders, phone calls, offering transportation, etc.
The MCO should assist the CM in identifying those BH HCBS providers that are ready for referral.
BH HCBS Individual Service Plan (ISP) and Authorization of Ongoing BH HCBS: BH HCBS Provider develops ISP and submits Prior Auth (on State template) that includes scope, duration, frequency to MCO.
MCO issues determination on authorization request for BH HCBS scope, duration, frequency.
CM continues to work on Full NYS CMHA within 90 days and update POC as appropriate, without holding up BH HCBS or other new referrals. Goal is to keep individual engaged and connect to services to meet their need as soon as possible. CMHA and POC completed within identified timeframes.
CM works with all providers to add required detail/feedback to POC and obtain signatures needed, including BH HCBS providers.
MCO monitors for completion of Full CMHA within 90 days, and confirms POC updated and implemented.
Ongoing monitoring of Plan of Care by CM through work with Member and coordination with Providers and MCO.

HCBS Workflow

- ✓Health Home (HH) Care Managers Conducts Brief Eligibility Assessment
- ✓Health Home Care Managers Submits Minimum Requirement to Managed Care
- ✓MCO issues Level of Service Determination
- ✓HH Care Managers Refers Member to HCBS Provider
- ✓HCBS Provider Notifies MCO of receipt of referral and date of first scheduled appointment
- ✓Adult BH HCBS Provider notifies MCO and HH Care Manager of Frequency, Scope, and Duration
- ✓Health Home Care Manager Submits Full Plan Of Care (POC) with all federal requirements. Must be submitted in a written form with required signatures

Adult BH HCBS Prior and/or Continuing Authorization Process

Adult BH HCBS Authorization

- NYS encourages providers to reach out to the MCO/BHO regarding authorization protocol to ensure timely delivery of services for members.
- Adult BH HCBS Providers must complete the prior authorization form after establishing frequency, scope and duration.
- When requesting concurrent authorizations, the HCBS provider can choose to either:
  - 1) complete this form and submit it to the managed care plan for review (which may include a subsequent telephonic review if requested by the plan); or
  - 2) request a telephonic review only with the plan to discuss progress made and any modified goals/objectives.

Person-Centered Planning & Recovery

Bringing it all Together: The Comprehensive, Integrated Plan of Care

Recovery is a journey of healing and transformation enabling a person with a mental health or substance use problem to live a meaningful life in a community of his or her choice while striving to reach his or her full potential."

(The Council on Quality and Leadership)

Person-Centered Planning

SAMHSA defines “Person-Centered Planning” as a **collaborative process** where service recipients participate in the development of goals and services provided, to the greatest extent possible. Effective person-centered planning strengthens the voice of the individuals, builds resiliency, and **fosters recovery**. The process of developing a person-centered Plan of Care is supported by the **development of a partnership** and process for collaboration between the Health Home Care Manager and the individual receiving services.

BH HCBS & The Plan of Care

Federal Requirements consistent with Person Centered Planning

- Reflects that the setting in which the individual resides is chosen by the individual.
- Reflects the individual’s strengths and preferences
- Reflects clinical and support needs as identified through an assessment of functional need
- Includes individually identified goals and desired outcomes
- Reflects the services and supports (paid and unpaid) that will assist the individual to achieve goals
- Reflects risk factors and measures in place to minimize them
- Is understandable (written in plain language) to the individual receiving services and supports

*Full Plan of Care training available through MCTAC.org

*State issued BH HCBS template and checklist available on NYS DOH website

NYS Process for Conflict Free HCBS Referrals

- HARP enrollees shall be provided with a choice of HCBS designated providers from the MCO's network of a particular service.
- With respect to conflict-free care management requirements for Health Homes:
    - To promote and ensure integrated care for the best interest of the client, it is possible that an individual may receive care management and direct care services from the same entity, however, in these instances the care management and direct service components will be under different administrative/supervisory structures.

Care Planning in Practice

During the Person-Centered Planning process, the Care Manager needs to provide important information regarding services, supports, and resources in order to **enable the person to participate fully and effectively**. Some tips on how to provide this information include:

- ✓ Assess the person's knowledge and awareness of their chronic health conditions and treatment options
- ✓ Use appropriate, understandable language; avoid acronyms and abbreviations
- ✓ Provide visuals, including charts or diagrams when necessary
- ✓ Have copies of brochures for service providers and community resources (ask local organizations for extra copies of their marketing materials)
- ✓ Provide Fact Sheets on diagnoses and/or services
- ✓ If available, share outcome data from provider agencies
- ✓ Offer to share copies of this information with natural supports (parents, spouses, friends), if an appropriate release has been signed

*Full Plan of Care training available through MCTAC.org

HCBS Business Rules

HCBS Utilization Thresholds

HCBS services will be subject to utilization caps at the recipient level that apply on a calendar year basis. These limits will fall into three categories:

1. Tier 1 HCBS services will be limited to $8,000 as a group. There will also be a 25% corridor on this threshold that will allow plans to go up to $10,000 without a disallowance.
2. There will also be an overall cap of $16,000 on HCBS services (Tier 1 and Tier 2 combined). There will also be a 25% corridor on this threshold that will allow plans to go up to $20,000 without a disallowance.
3. Both cap 1 and cap 2 are exclusive of crisis respite. The two crisis respite services are limited within their own individual caps (7 days per episode, 21 days per year).

If a Plan anticipates they will exceed any limit for clinical reasons they should contact the HARP medical director from either OMH or OASAS and get approval for a specific dollar increase above the $10,000 effective limit.

Allowable Billing Combinations of State Plan and HCBS					
HCBS/State Plan Services	Clinic/OTP	ACT	PROS	IPRT/CDT	Partial Hospital*
PSR	YES				YES
CPST				YES/NO	YES
Habilitation	YES		YES	YES	YES
Family Support and Training	YES			YES	YES
Education Support Services	YES		YES	YES	YES
Peer Support Services	YES		YES	YES	YES
Employment Services	YES			YES	YES

*If a participant is admitted into a Partial Hospital program, their HCBS payments will be suspended so that their services will not be terminated.
** All HARP Members are eligible for Crisis Respite Services

Allowable Billing Combinations of HCBS and HCBS							
HCBS Combinations	PSR	CPST	Habilitation	Family Support and Training	Education Support Services	Peer Support Services	Employment Services
PSR*		YES	YES	YES	YES	YES	YES
CPST	YES		YES	YES	YES	YES	YES
Habilitation*	YES	YES		YES	YES	YES	YES
Family Support and Training	YES	YES	YES		YES	YES	YES
Education Support Services	YES	YES	YES	YES		YES	YES
Peer Support Services	YES	YES	YES	YES	YES		YES
Employment Services	YES	YES	YES	YES	YES	YES	

* PSR and Habilitation may only be provided at the same time by the same agency.

** All HARP Members are eligible for Crisis Respite Services

CMS Settings Rule

Summary of CMS Final Rule Regarding Settings

The CMS final rule requires that all Home and Community Based settings meet certain qualifications.

These include that the setting:

- Is integrated in and supports full access to the greater community;
- Is selected by the individual from among setting options;
- Ensures individual rights of privacy, dignity, and respect, and freedom from coercion and restraint;
- Optimizes autonomy and independence in making life choices; and
- Facilitates choice regarding services and who provides them

CMS Settings Rule Cont.

- Under the final CMS rule, in a provider-owned or controlled residential setting, the following conditions must be met:

1) The unit can be owned, rented or occupied under an agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under landlord tenant law.
2) Each individual has privacy in their sleeping or living unit:
   - Units have entrance doors lockable by the individual, with only appropriate staff having keys to doors as needed.
3) Individuals sharing units have a choice of roommates in that setting.
4) Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.
5) Individuals have the freedom and support to control their own schedules and activities, and have access to food at any time.
6) Individuals are able to have visitors of their choosing at any time.
7) The setting is physically accessible to the individual.

Summary

- A variety of treatment and rehabilitation services are available through the NYS State Plan, Medicaid Managed Care (Mainstream), and HARPs.
- The HHCM's role is to provide the individual with enough information to make an informed and meaningful choice of services and providers.
- The HH Workflow and Expedited Workflow are tools for the HHCM to use when supporting an individual with accessing BH HCBS.
- Resources and training are available through OMH, OASAS, DOH, and MCTAC.

Frequently Asked Questions

Frequently Asked Questions

- Are Home and Community Based Services (HCBS) only made available for HARP eligible clients?
  - Yes, HCBS services are only available to clients that are enrolled in a HARP or an HIV SNP after they've undergone a brief and full assessment using the New York State Community Mental Health Assessment and the assessment has indicated that they are eligible and for which services. For more information consult a recent workflow presentation.

- Will Managed Care Organizations know who the designated Home and Community Based Services (HCBS) providers are? How will CM know who the HCBS providers are and which ones are in each plan's network?
  - Yes, Plans are provided this information and the list of the designated providers is also publicly available on the OMH website, and can be accessed here. CM should have a list of designated providers and should also have a list of HCBS providers in each plan's network.

- Can homeless clients use the Crisis Respite Home and Community Based Service?
  - If an individual is HARP eligible, yes, but note that Crisis Respite has usage caps outlined in the HCBS manual and MCTAC trainings.

- How do agencies identify if a client is HARP/HCBS eligible?
  - HARP/HCBS eligibility information is available using ePaces.

- Are HARPs required to have case managers? How are clients assigned to Home Health Care Managers?
  - Yes, HARPs are required to have case managers. The expectation is that most face to face care management will be done through the Health Homes. Each Health Home has its own assignment process.

For additional questions, please follow-up with an email to the appropriate state office:

OASAS: picm@oasas.ny.gov

OMH: OMH-Managed-Care@omh.ny.gov