



HEALTHY MINDS FOR A HEALTHY NEW YORK

Transitioning to Community Services: HARPS, Health Homes and SPOA

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Brief History of Health and Recovery Plans (HARPs)

The Governor's Medicaid Redesign Team for Behavioral Health recommended that the funding for behavioral health move from a fee for service structure to a capitation model (Managed Care).

Medicaid Managed Care Plans have already been utilized for individual's physical health needs for those with a mental illness

Advocates fought to add benefits beyond the traditional covered Medicaid services

In response, the State created a HARP product line that would provide additional benefits for 140,000 individuals in the Public Behavioral Health System

What is a HARP?

- The acronym HARP stands for **Health and Recovery Plans**.
- HARPS are a Medicaid Benefit Product Line.
- They are part of the Home and Community Based Services (HCBS) 1915 I Waiver.
- Of the 800,000 New Yorkers in the Public Mental Health System, 140,000 qualify for the additional HARP benefit

Existing Medicaid Services for Behavioral Health Enrollees

With Medicaid Managed Care, most of the 800,000 individuals in the public mental health system will be eligible for existing Medicaid Plan Services which includes:

- Clinic Services
- Inpatient
- Assertive Community Treatment Teams
- Personalized Recovery Oriented Services (PROs)
- Continuing Day Treatment
- Medication Management
- Detox Services
- Residential Treatment for Substance Abuse Services
- Opioid Outpatient Treatment (new)

HARP level of services are different than traditional Medicaid services

HARP Services cover specialty services that many community advocates have long fought for in their programs.

All Individuals Eligible for HARP Services will receive all benefits in the existing Medicaid Plan but will also have access to non Traditional Services that are now Medicaid Billable including

- Peer Support
- Psychosocial Rehab
- Short and Long Term Crisis Intervention
- Educational Supports

What are HARP Services (*con't*)?

- Employment Supports
- Family Engagement
- Self Directed Services
- Non-Medicaid Transportation for Medicaid Community Services
- **Transition Specialists and Peers: Education about HARP before they are discharged from nursing homes.**

The Potential of HARP Services

Great potential for changing the landscape of behavioral health in New York.

Helps people improve the quality of their life, including getting and keeping jobs, getting into schools and graduating, managing stress and living independently.

- peer services,
- family engagement,
- supported employment,
- supported education

These are now an integral part of the individual's plan of care that identifies life goals and services needed to help people reach their goals

Who with Behavioral Health Needs is not eligible for Medicaid Managed Care?

Groups that are **not** currently eligible for Medicaid Managed Care (including the enhanced HARP benefit), include:

Individuals who are dual eligible (Medicaid and Medicare)

Non Medicaid individuals

Individuals in Managed Long Term Care Plans (MLTC)

Individuals Currently Living in Nursing Homes

Under Age 21

Have Services through the Office of People with Developmental Disabilities (OPWDD)

OBSTACLES IN THE WAY OF HARP IMPLEMENTATION

Of the 140,000 people expected to be in HCBS services through the HARP statewide, less than a thousand people have enrolled.

Reasons

- Not enough peers know about HARP Services. There has not been enough peer education in the communities. As a result, people don't realize that this is an additional benefit that can have a positive impact

Additional Obstacles

- Many providers are still not Medicaid ready. There has been difficulty in transforming small not for profits into Medicaid billing entities.
- Insurance Plans are still not clear on how these programs work.
- Reimbursement rates for some of the HARP services are not sustainable.
- Concern about policy on the Federal Level since underlying funding for HARPs are a manifestation of the ACA

What is a Health Home?

- Health Home are not physical structures.
- Health Homes are regional partnerships comprised of health care and service providers to make sure people get the care they need.
- A Care Manager is assigned to everyone enrolled in a Health Home.
- Hallmark of Health Homes are a number of providers agencies dedicated to meeting need of consumers through engagement in services (including mental health services, substance abuse services, medication, some housing and links to social services)

Who is eligible for a Health Home?

Single Qualifying Condition for placement is only for serious mental illness and HIV

Otherwise you must have two qualifying chronic conditions

Having one chronic condition and being at risk of developing another condition does not qualify an individual as Health Home eligible

Substance Use Disorders are considered chronic conditions, but do not by themselves qualify an individual for Health Home services

Health Home Concerns

- Behavioral Health Shift - Traditionally, mental health care coordination utilized the model of Intensive Case Managers and Supported Case Managers. Health Home model changed that and include other individuals on Medicaid and not just behavioral health individuals. Still adjusting to change.
- More training is needed in behavioral health for care managers. For example in DSRIP, Hot Spots have not always identified individuals with behavioral health needs. Need more mental health education.
- **Transition Specialist/Peers should take advantage of behavioral health trainings.**
- Frustration voiced about outreach and engagement services. Workforce is under compensated and not provided with the resources necessary to engage individuals.
- Case loads are very high and the high, medium, low categories of health home care management has not always been successful.

Referral Process for HARP Services and Health Home Engagement

- Based on past use of services for individuals on Medicaid, 140,000 people have been identified as HCBS eligible for HARP Services.
- If you are already in a Health Plan that provides HARP Services, you are automatically enrolled in that HARP (passive enrollment).

The Recipient Referral Process for HARP Services

- The Health Home or Health Plan sends a letter notifying the recipient that they have access to the HARP plan. They can choose to stay in or they can opt out of the services.

This letter contains information about choosing a HARP, what to do next and most importantly where to get more information through NYS Medicaid Choice at 1-855-789-4277.

- If you choose to enroll in the HARP program, you will be assigned a Health Home Care Manager who will provide an assessment to determine Plan of Care for HARP Services. (Still finding out if the assessment can be done offsite and in advance of community transition)

This is an important point of engagement for the Transition Specialists and Peers to infuse themselves into the Plan of Care discussion. They should ask the enrollee if they can be involved with them in the Plan of Care conversation.

- The Health Home meets with the Health Plan to determine the level of services requested in the Plan of Care.

In collaboration, the Health Plan, the Health Home (through the Care Manager) and the individual will work together to identify community designated HARP providers who can provide the services in the Plan of Care.

SPOA (Single Point of Access)

- Roots in initial tenants of care coordination as part of Kendra's Law.
- Idea was to bring together counties and providers to discuss referral processes for individuals in a systemic way including those hardest to serve in communities.
- Each individual county has their own SPOA process.
- 'If you've seen one County SPOA, you've seen one county SPOA'

Where Do Health Homes and SPOAS Intersect?

- Adult SPOA for Care Coordination is not as active since creation of Health Homes.
- Health Homes often will subcontract with Case Management Agencies (CMA's) to do coordination of services.
- While some of the CMA's work closely with the SPOA team in some counties, there are many counties where this does not happen.
- Where SPOA and Health Homes intersect is with individuals who are court ordered with Assisted Outpatient Treatment.

SPOA ROLE

- Most counties have two SPOAs—Adult SPOA comprised of Case Management and Residential Services and Children’s SPOA.
- Outside of AOT, the role of SPOA for adult case management is with non-Medicaid individuals in need of mental health services.
- SPOA is involved in the adult housing side. Health Homes are also involved in residential placements but not to the same degree as SPOA. Most referrals for housing take place through SPOA except in NYC where it is done through the Human Resources Administration (HRA)
- **Transition Specialists/Peers—Make sure you have contact info for both the regional health home and the County SPOA program since they may provide initial entry into the adult system of care when transitioning out of a nursing home.**

Resources

New York Medicaid Choice at 1-855-789-4277

NYS Office of Mental Health (OMH):

<http://www.omh.ny.gov/omhweb/bho/changes-bh.html>

NYS Office of Alcoholism and Substance Abuse Services (OASAS):

<http://www.oasas.ny.gov/mancare/index.cfm>

NYS Department of Health (DOH):

http://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/consumer_info/index.htm

For information about Behavioral Health Home and Community Based Services (BH HCBS):

<http://www.omh.ny.gov/omhweb/bho/hcbs.html>

For information about Health Homes:

http://www.health.ny.gov/publications/1123/hh_brochure.pdf