2019 HOMELESS SYMPOSIUM

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Excellus BlueCross BlueShield
LIVE FEARLESS

A nonprofit independent licensee of the Blue Cross Blue Shield Association

OUR MISSION

To help people in our communities live healthier and more secure lives through access to high-quality, affordable health care.

OUR VISION

To be recognized and valued as THE community and business resource for health care security through financial strength, effective cost control, ease of use, and commitment to health improvement.

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AGENDA

- Accessibility- Who & How?
- Services offered
  - Facilitated Enroller
  - Case Management
  - Community Connections
- How we have become more involved
- Our Vision Moving Forward

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Accessibility

- Who can access Case Management services through the Health Plan?
  - All membership enrolled with Excellus BlueCross BlueShield
    - *HMO Blue Option*
    - *Blue Choice Option*
    - *Blue Option Plus*
- How can a member be referred to Case Management services through the Health Plan?
  - Self-Referral/Family Member
  - Providers
  - Community Agencies
  - Internal Referral
  - Risk Stratification Measures
  - Facilitated Enrollers

*Case Management at 1-844-694-6411

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Services Offered

- Facilitated Enrollers
- Case Management/Utilization Management
- Community Connections

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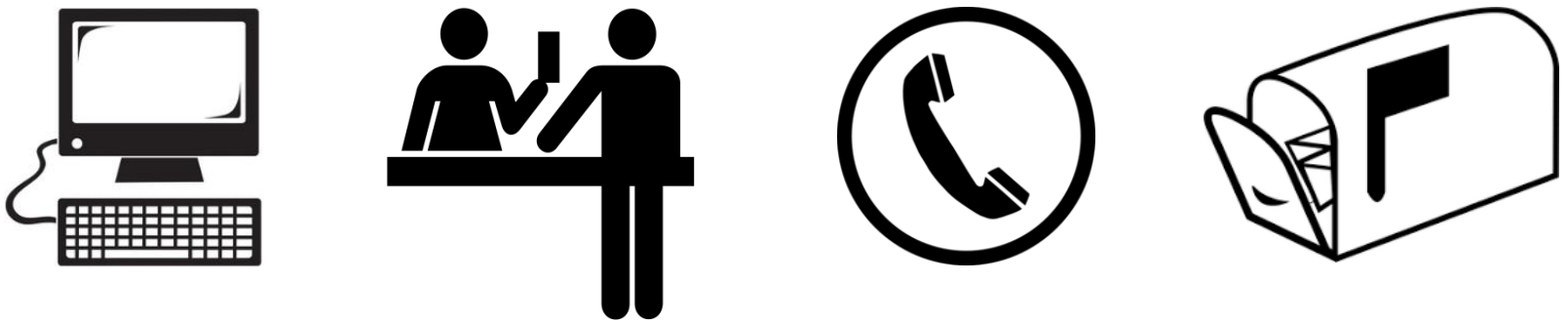
Marketplace Facilitated Enrollment

Marketplace History

- Under the federal **Affordable Care Act**, a "Marketplace" is required to operate in every state as of October 2013.

- A single application helps people check eligibility for health care programs including: Medicaid Managed Care, Child Health Plus, Essential Plan, and HARP.

- Marketplace applications can be completed:



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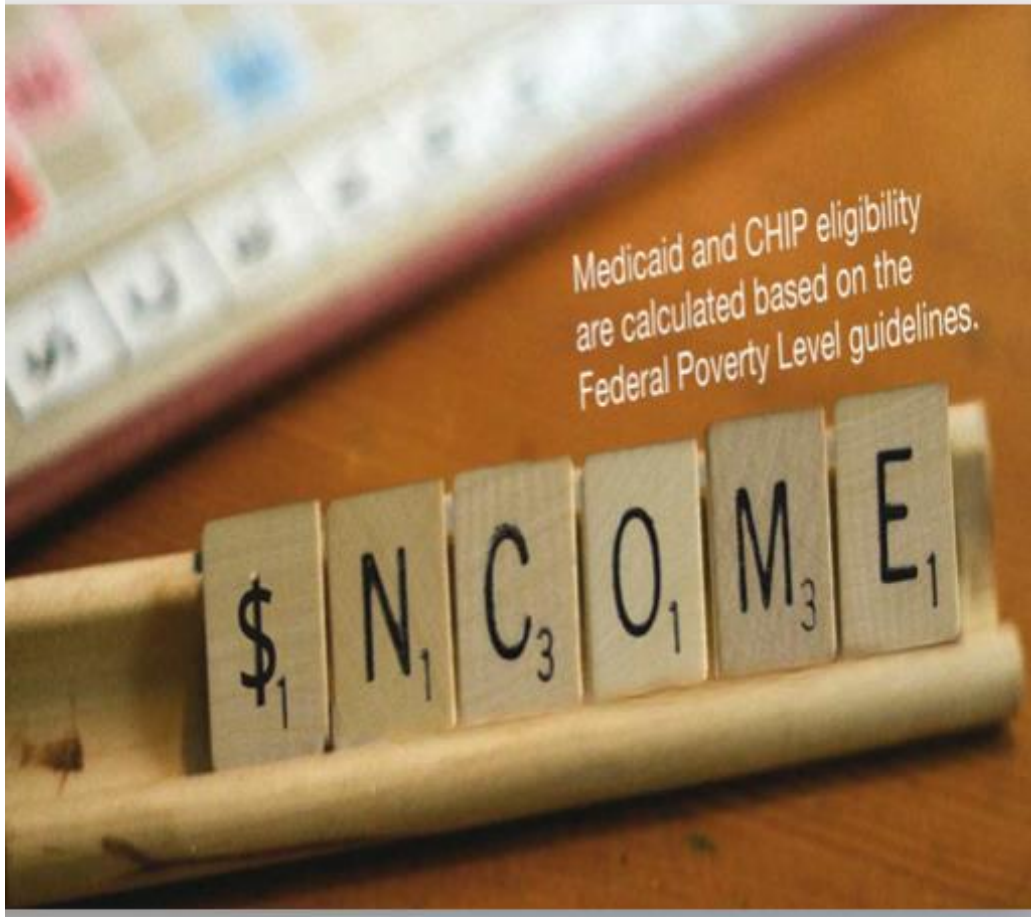
Government Programs Overview

- **Government Subsidized Programs** are health insurance programs, offered through regional national insurances and paid for fully or in part by the government for those who qualify.

- The State contracts with Health Plans and pays part of, or all cost of the premium for the individuals who meet the Federal Poverty Limits (FPL).

- The Federal government adjusts the FPL each year due to the annual cost of living increase.



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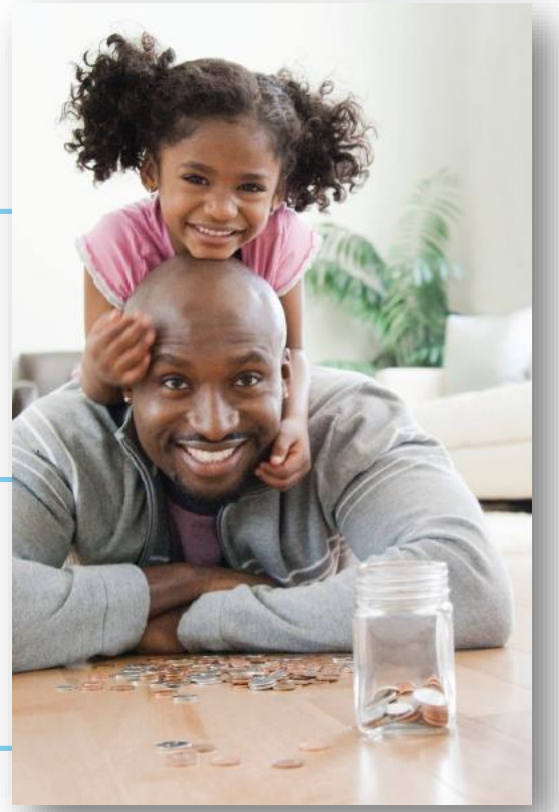
Affordable Health Care Act – Overview

Plans are based on age, household income and household size

Financial help may be available; average 4 out of 5 people qualify for financial assistance

No one can be denied coverage for pre-existing conditions

Enrollment available all year long for Child Health Plus, Medicaid Managed Care, Health & Recovery Plan (HARP) & Essential Plan health plan options



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Medicaid Managed Care (MMC)

Benefits / Coverage

- All regular medical checkups and needed follow-up care
- Family planning services
- Doctor & health clinic & specialist visits
- Medicine, medical supplies, medical equipment & appliances
- Lab tests and x-rays
- Eye care and eye glasses, dental care
- Emergency care, emergency ambulance transportation to a hospital
- Hospital services, including inpatient and outpatient
- Nursing home care

- **Available in most counties; see product map**

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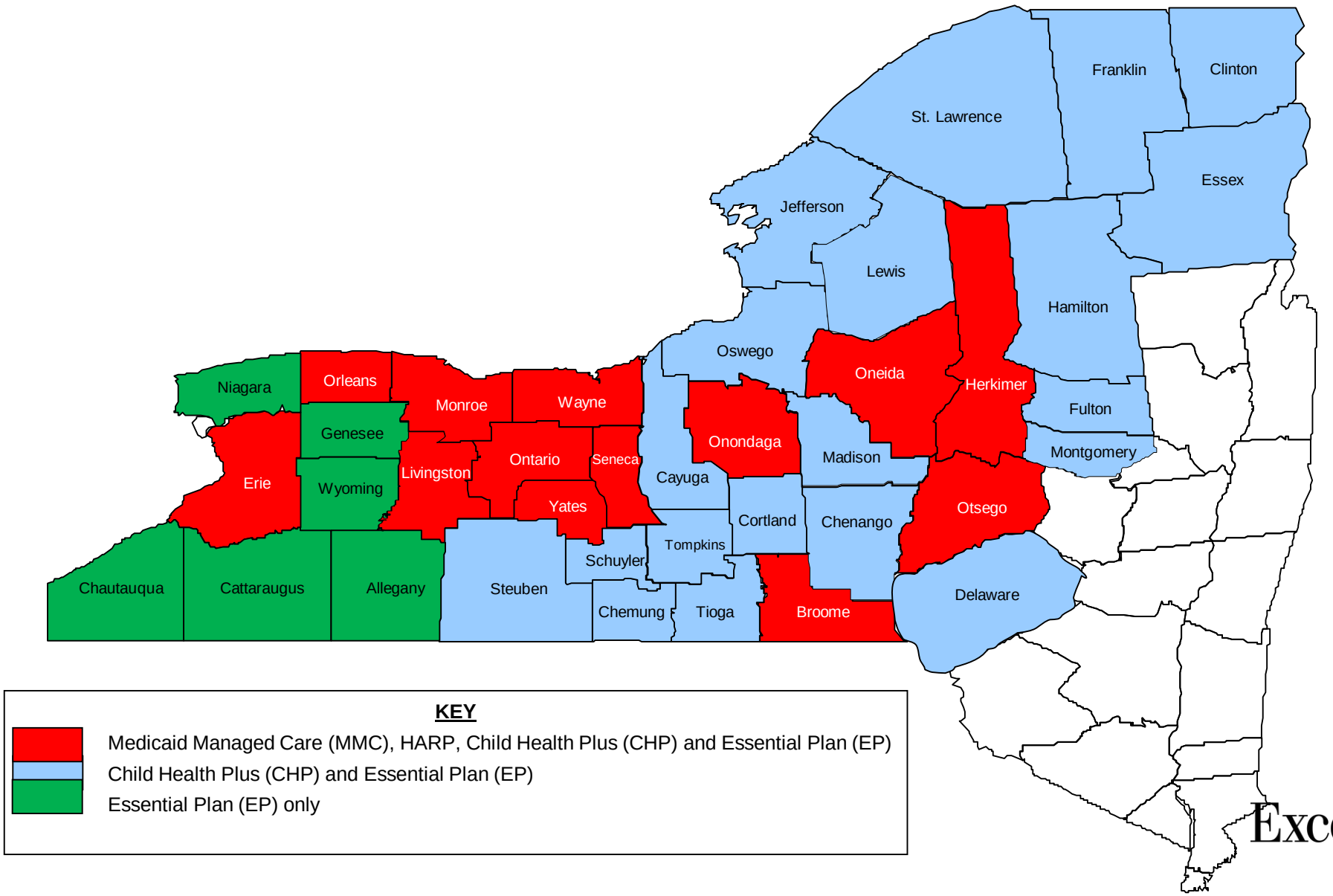
2019 Service County Map (as of 7/1/2019)



Medicaid Managed Care (MMC)

Eligibility Criteria

- Newborn-64 years of age - Populations include children, pregnant women, single individuals, families and individuals certified blind or disabled
- Must be a NY State resident
- Persons with medical bills may be eligible even if above allowable income levels
- Eligibility is determined by NYSOH and income / resource levels generally change on Jan 1 of each year
- Pregnant women; services may be limited if incomes are too high

Eligibility / Income Criteria	Premium Cost
Adult FPLs up to 138%	Zero Premium
Children Age 1 – 19 FPL Up to 154%	Zero Premium
Pregnant Women & Children under Age 1 – Up to 223% FPL	Zero Premium
19-20 Year old children living with parents – Up to 155% FPL	Zero Premium

*MMC FPL's located in the appendix

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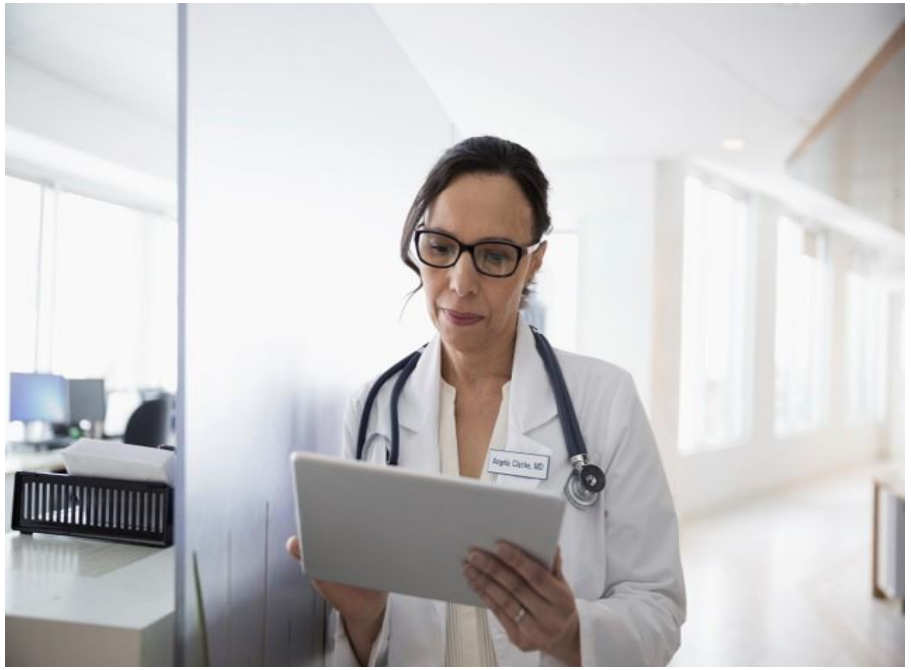
Typical Scenario– MMC

- Person has no health insurance and is need of medical services. Currently has no income or permanent residence. Household Size: 1 Adult
  - Household Income: 0
  - Resident: NYS resident in Monroe County
  - Immigration Status: N/A

- <u>Outcome:</u>
  - The person is eligible for Medicaid and can choose a Managed Care Plan. Plan will be active for one year and must renew after 12 months to remain active.



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Health and Recovery Program (HARP)

BH Carve In & HARP

- Fee-for-Service BH benefits were carved into MMC for adults 21 to 64 effective 7/1/16
  - Benefit Carve In
- New Excellus BlueCross BlueShield Health and Recovery Plan (HARP)
  - **BH Special Needs Plan**
  - Medicaid-eligible members with Severe Mental Illness or Substance Use Disorder
  - Same 13 county service area as MMC
  - Once Medicaid application is submitted, State will determine eligibility

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Health and Recovery Program (HARP)

Benefits

- Inpatient - SUD and MH
- Clinic – SUD and MH
- Personalized Recovery Oriented Services (PROS)
- Intensive Psychiatric Rehabilitation Treatment (IPRT)
- Assertive Community Treatment (ACT)
- Continuing Day Treatment (CDT)
- Partial Hospitalization
- Comprehensive Psychiatric Emergency Program (CPEP)
- Opioid Treatment
- Outpatient Chemical Dependence Rehabilitation

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Health and Recovery Program (HARP)

Home and Community Based Services

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

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Marketplace Facilitated Enroller Role (MFE)

- ✓ Less chance for errors as MFE is familiar with process
- ✓ More accurate eligibility determination will result in more accurate monthly payment. (less headaches during tax time)
- ✓ MFE is continuously trained and made aware of any updates and new programs
- ✓ Maximize efficiency / save time
- ✓ Avoid lapses in coverage
- ✓ **"MFE MUST BE HEALTH PLAN NEUTRAL - Enrolling on behalf of NYSOH"**

WE CAN HELP IN PERSON.
A trained Facilitated Enroller can help determine plan eligibility, estimate monthly payments, and select the best plan from multiple insurers, saving time and improving accuracy while avoiding any lapse of coverage.

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Contact information

- Call to **schedule** *face to face appointments to enroll or renew* with Marketplace Facilitated Enrollers:
  - **1.800.234.4781**

- *"Enroll America survey finds that over 80% of consumers would recommend in-person enrollment assistance to a close friend."*

source: enrollamerica.org

- Tameria Terrell, Facilitated Enroller
  - 585.339.3838
  - Tameria.terrell@Excellus.com

- www.nystateofhealth.ny.gov or 1.855.355.5777

nystateofhealth™
The Official Health Plan Marketplace

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Case Management

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Once Someone is Enrolled

- Disease Management
- Utilization Management
- Complex Care Management
  - Physical Health Case Management
  - Behavioral Health Case Management
- Long Term Support Services
- Bright Beginnings for Moms and Babies
- Embedded CMs (Rochester General Hospital, Helio, House of Mercy)
- Children's Case Management – Behavioral Health/Physical Health/Foster Care/Medically Fragile
- Community Connections

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Case Management

- Case Management for Each Focus Area
  - Education
  - Assessment
  - Member focused goal setting
  - Community Referrals
  - Collaboration
- External Collaboration – Primary Care Physician/Therapist/Psychiatrist, family, Health Home Care Management Agencies, Community Based Organizations
- Internal Collaboration – Weekly department case review, consultation with medical directors, monthly interdisciplinary case review, supervision

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Behavioral Health Case Management

- Medium to High Intensity Case Management
- Member-Driven Goal Development and Action Planning
- Special Attention to:
  - Clinical presentation and knowledge of clinical history
  - Pharmacy support and guidance
  - In-network medication-assisted treatment support
- Referral to
  - Health Home Care Management
  - HARP/HCBS
  - Mental Health/Substance Abuse/Primary Care providers
  - DHS/Housing/Food/Clothing resources
- Ongoing Assessment and Collaboration - Clinical Case Reviews

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Community Connections

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Community Connections

- "Boots on the ground" team in the "relentless pursuit of engagement"
- Locating members that are most difficult to find, unable to contact, or who are lost to contact
- Approx. 1200 referrals received each quarter from PH and BH Case Management Departments
- 47-50% successful contact rate!!!! (national average for similar programs: 35-38%)
- Establishing community resource partners (CBO) and updating our SN Community Resource Guide
- Participation in multiple community events such as the Puerto Rican Festival, Jordan Health Center Health Fair, and Rochester Regional Health Summer Safety Event
- Special projects-HEDIS Gaps in Care campaigns, Risk Adjustment, Case Management initiatives

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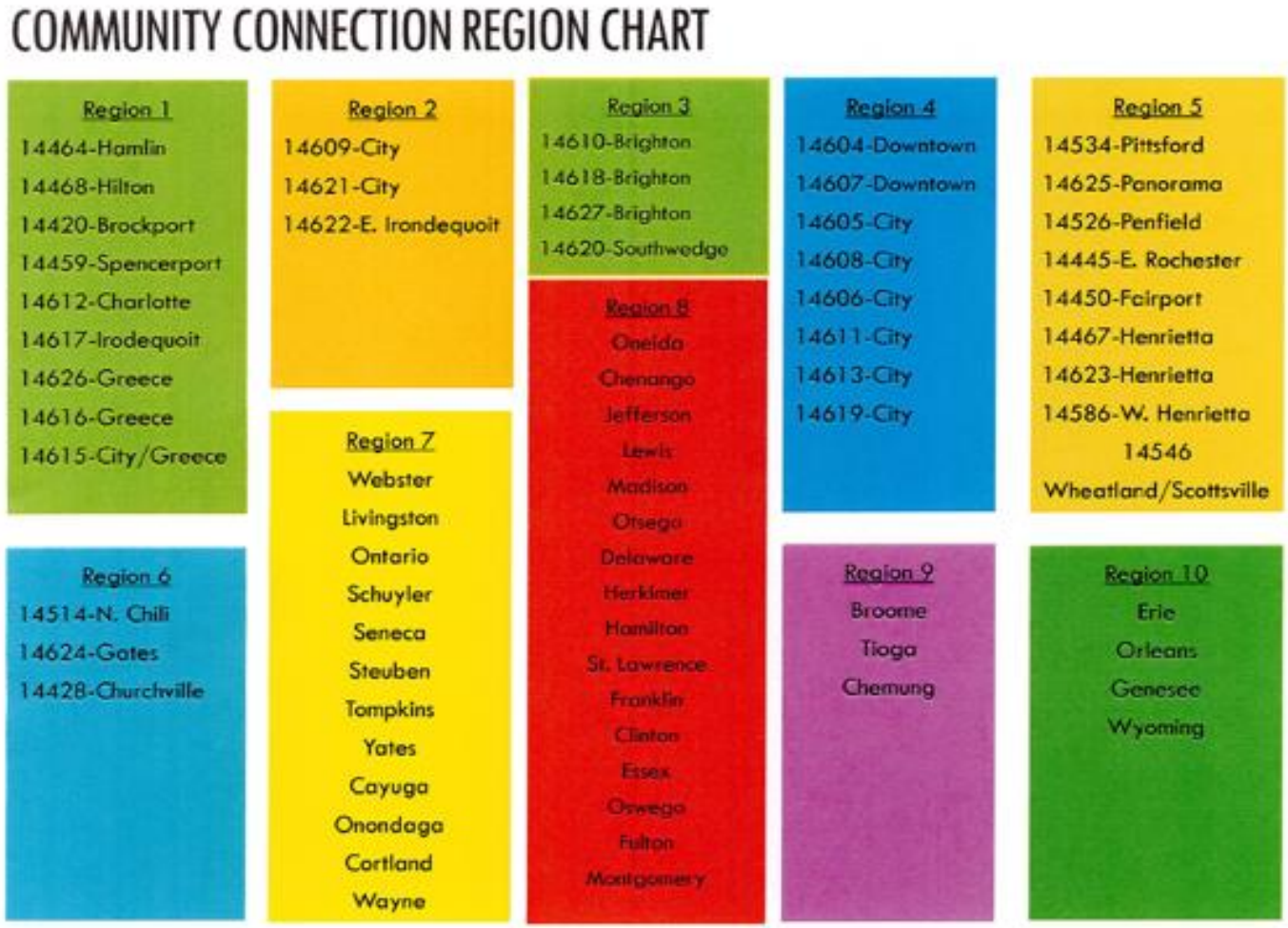
Community Connections Regions



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Community Connections Home Visit

- Community CARE Connections – A safe place for baby to sleep;
  - https://www.youtube.com/watch?v=FFMLhc8YQ-Y
- Community Connections Representatives have cultivated contacts in the community – churches, government agencies, nonprofits, etc. – who can help employees secure items for our members such as:
  - Special formula for premature babies
  - Food
  - Help with an eviction
  - Government-subsidized cell phones
  - Beds for a family sleeping on floors
  - Car seats for newborns

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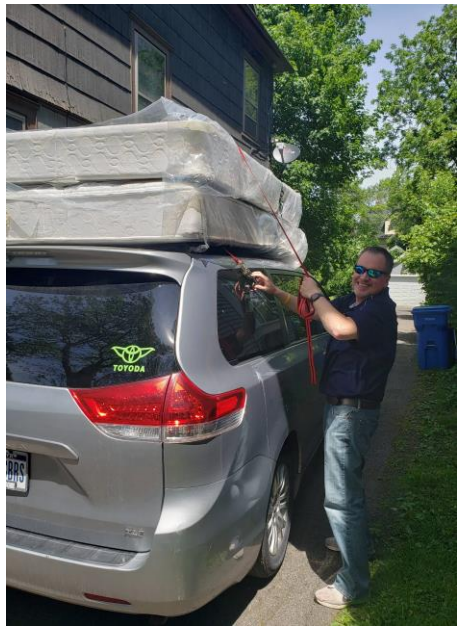
Community Connections and Case Management Integrate

- **The SN C.A.R.E. Team's Relentless Pursuit of Engagement**
- Barb Henry, LTSS Case Manager sent a Community Connections referral for a member in need of a bed.
- Member was evicted from her home and living with her son.
- Sylvia Lee, Manager of SN Community Outreach Programs mention the need to Brian Shevlin, Manager of Medical Specialty Drug. Brian advised Sylvia that he had a queen-sized bed and frame that he was looking to donate.
- Sylvia and Brian delivered the bed to the member.
- The member had tears in her eyes and stated how blessed she was to have a wonderful Case Manager like Barb who found two angels to bring her a bed.



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Expanding Work with our Homeless Members

Where We Started

More wholistic approach to health	Focus on specialty populations – First Episode Psychosis, Recently Incarcerated, Homeless
Report of Homeless generated from Medical Analytics Performance Portal (MAPP)	Outreaching members – or contacting Health Home Care Manager
Community Connections referrals completed if no contact with members	
Shifted approach to create partnerships with agencies already reaching our members	Case Management Agencies, Homeless Shelters
Attending community meetings	Chronic Homeless Workgroup, Homeless Services Network, Health and Housing, Point in Time surveys
Focus on Social Determinants of Health	Identify areas of need and how to best use efforts to impact members' ability to stay healthy

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Social Determinants of Health

- Excellus BCBS has been working to build the infrastructure that integrates the social determinants of health into the area of value based healthcare
  - Vendor identifies the social needs at scale
  - Identifies financial impact of intervention
  - Operationalize campaigns to resolve identified needs
- Working to identify actionable interventions
  - Housing Stability, Food Security, Neighborhood Stress

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Where We Are Now

Attend community meetings and strengthen current partnerships (always open to creating more)

Continue to use community connections where appropriate

Embedded Case Manager at House of Mercy

*Office time at House of Mercy 2x a week

*Provide Direct Enrollment into Health Homes

*Identify status of Housing Applications

*Collaborate engagement with Health Home Care Manager

Facilitate internal trainings related to Homeless services in the community (DHS, Partners Ending Homelessness)

Facilitate partnership with YWCA and coordinating donation drive across the region for early October

Explore options with other providers to explore additional areas of focus to reach and meet the needs of our members

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Working with House of Mercy

- Since May 2019
  - Over 65 visits, over 45 of those with Excellus BCBS members (deduplicated – 17 members)
  - Direct Enrollment Referrals – 31%
  - Already enrolled with Care Management Agency – 31%
  - Currently working with Care Management Agency or Assertive Community Treatment (ACT) – 62%
  - HARP Enrolled/Eligible – 56%
- Scenario

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Where We Are Going

- Continue to explore opportunities for partnership with other providers (Finger Lakes Performing Provider Systems (FLPPS), Case Management Agencies (CMAs), etc)
  - To find additional areas of focus to reach and meet the needs of our members and help improve overall health
- Coordinate trainings with Physicians Networks (Accountable Health Partners (AHP)/Greater Rochester independent Practice Association (GRIPA))
  - To provide information/tangible ways to address needs of homeless patients
- Continue to increase member self-sufficiency, accountability and empowerment

GOAL: Create efficient and strong infrastructure between member and all service providers to meet their needs and improve overall health

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Our Vision

"Improve access to care."

"To educate."

"To fight for adequate care."

"To break the stigma."

"Increase collaboration across all forums."

"To be a support."

"To make someone's day better."

"Stop prejudices in how health care is offered."

"To be a bridge in a broken cycle."

"Offer understanding."

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QUESTIONS?

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THANK YOU

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